

# Application for a §1915(c) Home and Community-Based Services Waiver

## PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

## Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

### 1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

Significant changes to this renewal include:

- 1) Revised performance measures related to: Administrative Authority, Participant Access and Eligibility, Participant Services, and Participant-Centered Planning and Service Delivery
- 2) Revised the number of unduplicated participants;
- 3) Added Specialized Therapies as a waiver service
- 4) Revised Participant Direction of Services to include a “common-law” employer option for self-direction
- 5) Updated Program Integrity Unit financial accountability reviews

## Application for a §1915(c) Home and Community-Based Services Waiver

### 1. Request Information (1 of 3)

**A. The State of South Dakota** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

**B. Program Title** (*optional - this title will be used to locate this waiver in the finder*):

South Dakota Family Support 360 Waiver

**C. Type of Request:** renewal

**Requested Approval Period:** (*For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.*)

3 years    5 years

**Original Base Waiver Number:** SD.0338

**Draft ID:** SD.002.05.00

**D. Type of Waiver** (*select only one*):

Regular Waiver

**E. Proposed Effective Date:** (mm/dd/yy)

06/01/22

**PRA Disclosure Statement**

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

**1. Request Information (2 of 3)**

**F. Level(s) of Care.** This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (*check each that applies*):

**Hospital**

Select applicable level of care

**Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

**Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160****Nursing Facility**

Select applicable level of care

**Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

**Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140****Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

## 1. Request Information (3 of 3)

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**G. Concurrent Operation with Other Programs.** This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

**Not applicable**

**Applicable**

Check the applicable authority or authorities:

**Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

**Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

**Specify the §1915(b) authorities under which this program operates** (*check each that applies*):

**§1915(b)(1) (mandated enrollment to managed care)**

**§1915(b)(2) (central broker)**

**§1915(b)(3) (employ cost savings to furnish additional services)**

**§1915(b)(4) (selective contracting/limit number of providers)**

**A program operated under §1932(a) of the Act.**

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

**A program authorized under §1915(i) of the Act.**

**A program authorized under §1915(j) of the Act.**

**A program authorized under §1115 of the Act.**

*Specify the program:*

**H. Dual Eligibility for Medicaid and Medicare.**

Check if applicable:

**This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

## 2. Brief Waiver Description

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**Brief Waiver Description.** *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The South Dakota Family Support 360 Waiver is for participants with intellectual or developmental disabilities (I/DD), and is for participants who self-direct their services and supports.

The goal of the Family Support 360 Waiver's services, when used in conjunction with non-waiver Medicaid services and other generic services and natural supports, is to provide for the health and developmental needs of participants who otherwise would not be able to live in a home and community based setting.

Guiding principles or objectives for family support include the following:

1. A philosophy that services must not be confined to a single set of services;
2. Family support recognizes the importance of family and the support necessary to keep the participant in their home environment;
3. Family support's focus is on the whole family;
4. Family support is flexible to changing needs of families and participants;
5. Family support promotes inclusion in all aspects of life;
6. Families are included in policy making, planning, implementation, and personal and programmatic decisions;
7. Families are empowered to make decisions regarding their own needs;
8. Family support is respectful of cultural preferences and orientation; and
9. Family support is able to assist participants across the life span.

The Division of Developmental Disabilities (DDD) of the Department of Human Services (DHS) through a Memorandum of Understanding (MOU) with the Department of Social Services (DSS), the Single State Medicaid Agency (SSMA), operates the Family Support 360 Waiver for participants with I/DD. This waiver provides services and payment for those services that are not offered under the State Medicaid Plan. This waiver is operated on a statewide basis. Support Coordination is provided by qualified Medicaid providers. These support coordinators assure that the participant's needs are assessed and identified for each service.

### 3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the state provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

**Yes. This waiver provides participant direction opportunities.** Appendix E is required.

**No. This waiver does not provide participant direction opportunities.** Appendix E is not required.

- F. Participant Rights.** Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy.** Appendix H contains the Quality Improvement Strategy for this waiver.

**I. Financial Accountability.** **Appendix I** describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

**J. Cost-Neutrality Demonstration.** **Appendix J** contains the state's demonstration that the waiver is cost-neutral.

#### 4. Waiver(s) Requested

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**A. Comparability.** The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

**B. Income and Resources for the Medically Needy.** Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):

**Not Applicable**

**No**

**Yes**

**C. Statewide.** Indicate whether the state requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):

**No**

**Yes**

If yes, specify the waiver of statewide requirements that is requested (*check each that applies*):

**Geographic Limitation.** A waiver of statewide requirements is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state. *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

**Limited Implementation of Participant-Direction.** A waiver of statewide requirements is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state. *Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:*

#### 5. Assurances

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In accordance with 42 CFR §441.302, the state provides the following assurances to CMS:

**A. Health & Welfare:** The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are

provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

**B. Financial Accountability.** The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

**C. Evaluation of Need:** The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

**D. Choice of Alternatives:** The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

**E. Average Per Capita Expenditures:** The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

**F. Actual Total Expenditures:** The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

**G. Institutionalization Absent Waiver:** The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

**H. Reporting:** The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

**I. Habilitation Services.** The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

**J. Services for Individuals with Chronic Mental Illness.** The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

## 6. Additional Requirements

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*Note: Item 6-I must be completed.*

**A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the

participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

**B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

**C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

**D. Access to Services.** The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

**E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

**F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

**G. Fair Hearing:** The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

**H. Quality Improvement.** The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

**I. Public Input.** Describe how the state secures public input into the development of the waiver:

As DHS/DDD began to prepare for the Family Support 360 Waiver renewal many activities were completed to gather public input. Each person receiving services through the Family Support 360 program received a information on the opportunity to complete a satisfaction survey. DHS/DDD also held 6 Family and Self-Advocate Stakeholder sessions to provide information on the family support waiver renewal and receive feedback from participants and families. In addition, DHS/DDD engaged in regular conversations with the Family Support Council to discuss the waiver renewal. The Family Support Council, which is comprised of waiver participants or family members, continues to meet quarterly each year. These council meetings also allow the opportunity for public comment. Information about the Family and Self-Advocate Stakeholder session was distributed via email to several stakeholder groups and was posted on the DHS/DDD website. Information about the Family Support Council meetings was distributed via email to stakeholder groups, posted on the DHS/DDD website, posted on the state Boards and Commissions website, and was posted in the DHS/DDD lobby.

As noted above each participant receiving services through the Family Support 360 program received a satisfaction survey. Approximately 23% of participants and/or their family members responded.

The Family Support 360 waiver administrator also presented to South Dakota's Medicaid Advisory Committee and to South Dakota Advocates for Change.

Additionally, public notice of the renewal was posted to the South Dakota Legislative Research Council's website.

There are nine Tribal Nations in South Dakota. Several avenues were taken to provide an opportunity to gather input into the Family Support 360 Waiver renewal from all nine Tribal Nations. The DHS/DDD Family Support Waiver Administrator met with representatives of the Tribal Nations at their quarterly tribal relations meeting. As public forum activities were planned the Chairperson/President of each Tribal Nation were invited, in February 2022, to attend the public forum. Lastly, in accordance with Presidential Executive Order 13175, each Tribal Chairperson/President received a letter in February 2022 from the DHS/DDD describing the Family Support 360 Waiver, the intent to renew the waiver, and the opportunity to meet face to face with DHS/DDD staff to further discuss the renewal.

Public notice of the Family Support 360 waiver renewal occurred between January 03, 2022 and February 02, 2022. Public notice was posted in a 24 hour accessible location within the DHS/DDD office. The public notice outlining proposed changes to the Family Support 360 waiver was posted to the DHS/DDD website for public access. The public notice provided interested parties with a link to the renewal application along with information on three avenues to offer comment that included e-mail, phone, and mail. The public notice also provided information on how to obtain a written copy of the renewal application. Additionally, the public notice information was posted at DHS/DDD satellite offices and the Department of Social Services.

Information on comments received during the public notice period can be found in Section B - Optional.

**J. Notice to Tribal Governments.** The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

**K. Limited English Proficient Persons.** The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

## 7. Contact Person(s)

**A.** The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

**Last Name:**

Ballard

**First Name:**

Matthew

**Title:**

Deputy Director

**Agency:**

Department of Social Services

**Address:**

700 Governors Drive Kneip Building

**Address 2:**

c/o 500 East Capitol Avenue

**City:**

Pierre

**State:**

South Dakota

**Zip:**

57501

**Phone:**

(605) 773-3495

Ext:

TTY

**Fax:**

(605) 773-5246

**E-mail:**

matthew.ballard@state.sd.us

**B.** If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

**Last Name:**

Sollars

**First Name:**

Jaze

**Title:**

Waiver Administrator

**Agency:**

Department of Human Services

**Address:**

Hillsview Plaza East Hwy 34

**Address 2:**

c/o 500 East Capitol Avenue

**City:**

Pierre

**State:**

South Dakota

**Zip:**

57501-5070

**Phone:**

(605) 773-3438 Ext:  TTY

Fax:

(605) 773-7562

E-mail:

jaze.sollars@state.sd.us

## 8. Authorizing Signature

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This document, together with Appendices A through J, constitutes the state's request for a waiver under §1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are **readily** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

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Signature:

State Medicaid Director or Designee

Submission Date:

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**Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.**

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State:

South Dakota

Zip:

Phone:

Ext:  TTY

Fax:

E-mail:

**Attachments****Attachment #1: Transition Plan**

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

**Replacing an approved waiver with this waiver.**

**Combining waivers.**

**Splitting one waiver into two waivers.**

**Eliminating a service.**

**Adding or decreasing an individual cost limit pertaining to eligibility.**

**Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**

**Reducing the unduplicated count of participants (Factor C).**

**Adding new, or decreasing, a limitation on the number of participants served at any point in time.**

**Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**

**Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

**Attachment #2: Home and Community-Based Settings Waiver Transition Plan**

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

*Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.*

*To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.*

*Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.*

*Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.*

The state assures that this waiver renewal will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any CMS required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan

Services in the Family Support 360 Waiver are provided only to individuals who are children living with natural, adopted, step-families or relatives who act in a parental capacity; adults living independently in the community; or adults living with a family member, legal guardian, or advocate. The services are intended to maximize independence and safety and supports community access and integration. Individuals do not reside in congregate settings. The Department of Social Services and the Department of Human Services presume all residential settings in the 1915(c) FS 360 waiver to meet the requirements of the federal regulation.

## Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

During the public notice period two requests were received for printed copies of the proposed renewal; these were provided. The Family Support 360 program received a letter of support from South Dakota Advocacy. Comments received during the public notice process are summarized below. Similar comments were grouped together.

Comment: Waiver recipients would benefit from having more independent opportunities for transportation. Training and supports should be developed through the waiver.

Response: The proposed waiver provides eligible participants with access to companion care services. This service is designed to assist waiver participants with skill acquisition; navigating transportation is allowable if desired by the participant. The Division of Developmental Disabilities also collaborates with public entities when requested to help address the transportation issues that affect all members of the community regardless of disability.

Comment: A gap exists in services between the ages of 12-21. Working parents/guardians do not have enough supports through the waiver to provide adequate supervision during their work hours.

Response: Although childcare is not a waiver service, the Family Support 360 program provides assistance to participants on the program whom need financial assistance with childcare. The family of a participant seeking childcare assistance is first referred to the Department of Social Services' Childcare Assistance program for eligibility through their programs. If denied, the Family Support program may be able to provide the financial assistance requested. The Family Support waiver also connects families of young adults on the Family Support program, up through the age of 21, with their local school district to identify options and opportunities for their young adult during the day as required by IDEA. The Family Support 360 Program also collaborates with Medicaid to ensure services available through EPSDT such as Private Duty Nursing are in place for individuals under age 21 when medically necessary.

Comment: The waiver should include a formal grievance process for individuals to voice concerns regarding the services they are receiving through the waiver in addition to the process for eligibility issues and denial of eligibility. The grievance procedure should reference South Dakota Advocacy Services as a resource for appeals.

Response: As found in Appendix F of the waiver renewal application, there are formal grievance procedures waiver participants may utilize at any time. Administrative Rules of South Dakota (ARSD) 46:11:03:06 requires each provider to have a formal grievance procedure approved by the DDD. The grievance procedures are required to incorporate annual training to the waiver participant and their guardian, if applicable; the ability to appeal any decision or action that affects the participant; the opportunity to obtain an advocate or employee of the state's designated protection and advocacy system; assistance with the grievance process if requested; and information on how to contact the DDD. ARSD 46:11:09:24 outlines appeal information specific to services. This rule requires that each participant be provided with information on how to obtain assistance from an employee of the state's designated protection and advocacy system as well as provided assistance in contacting said system if needed. Additionally, during the annual planning process, each participant/family/guardian is provided with information related to how to contact the DDD if there are concerns or they are not satisfied with services.

## Appendix A: Waiver Administration and Operation

**1. State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

**The waiver is operated by the state Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one*):

**The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

**Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

**The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

Department of Human Services (DHS), Division of Developmental Disabilities (DDD)

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (*Complete item A-2-b*).

## Appendix A: Waiver Administration and Operation

### 2. Oversight of Performance.

**a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

**As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.**

**b. Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

The DHS/DDD operates the Family Support 360 Waiver. DHS/DDD is a separate executive branch agency from the DSS, which is the designated SSMA. A MOU signed by the cabinet secretary of each department sets forth the responsibilities of each department.

DSS, to exercise administrative authority and supervision of the waiver, will:

- Authorize and pay all waiver claims through the DSS Medicaid Management Information System (MMIS);
- Review and approve/deny all waiver programs and amendments initiated by the DHS;
- Review and approve/deny all administrative rule changes related to waiver services proposed by DHS;
- Conduct random reviews of Title XIX expenditures (including waiver expenditures);
- Hold primary responsibility for the Title XIX eligibility determination process;
- Perform administrative hearings on waiver related issues;
- Make disability determinations when unavailable by Social Security Administration (SSA) due to financial ineligibility or pending determination status;
- Execute Medicaid provider agreements;
- Prepare and submit to CMS quarterly estimates and reports of actual expenditures of Title XIX funding;
- Explain to CMS variances between estimates and actual Title XIX expenditures;
- Drawdown all Federal Title XIX cash for the State of South Dakota;
- Review cost allocation plans involving Title XIX funding;
- Review and approve/deny all responses to federal reviews and audits involving Title XIX; and
- Monitor DHS operation of the HCBS waiver programs through review of annual reports detailing dissemination of information; assistance to enrollees; management of enrollment and expenditures; evaluation of level of care; review of payment amounts or rates; and review of participant plans.

DHS is delegated operational authority of the waiver and will:

- Develop regulations for new or revised waiver services for submission to DSS for review and approval/denial;
- Provide assurances to the DSS supporting appropriate expenditures of Title XIX funds;
- Meet sub-recipient audit requirements of the Single Audit Act and associated OMB Circular A-133;
- Disseminate information concerning the waiver to potential enrollees;
- Assist individuals in waiver enrollment;
- Manage waiver expenditures;
- Conduct level of care evaluation activities;
- Review participant service plans to ensure that waiver requirements are met;
- Perform prior authorization of waiver services;
- Conduct utilization management functions;
- Recruit and enrolls providers;
- Determine waiver payment amounts or rates;
- Conduct training and technical assistance concerning waiver requirements;
- Operate all DHS HCBS Waiver programs in compliance with all Federal and State statutes, rules and regulations; and
- Provide annual reports to DSS of operations detailing program implementation, clients served and such other performance measures as DSS specifies.

DSS will perform monitoring and oversight of delegated operational responsibilities of DHS. All initial and annual level of care determinations are referred by DDD to a DSS eligibility specialist for review and approval/denial. Notice, including right to appeal, is sent to each participant by DSS.

DHS performs prior authorization of waiver services. DSS provides oversight of this function through edit controls on the MMIS.

DHS calculates waiver payment amounts and/or rates in preparation for waiver application/renewal and submission of the 372 report to CMS. This information is then sent to the SSMA for review and approval/denial.

During the period prior to waiver application/renewal, DSS and DHS meet jointly to collaborate in completing each of the appendices of the new waiver template. DHS is responsible for drafting and forwarding each appendix to DSS, to include the state Medicaid director (SMD), director of economic assistance, and the chief financial officer, for review and approval/denial.

DHS as the operating agency has routine contact with the SMA regarding the waiver and its operation. This contact occurs at many levels between the OA and the SMA, the waiver manager, DDD management staff, DHS fiscal staff, and the Secretary of DHS. All work products of the operating agency are provided to the SMA for their review and approval. Examples include policy and procedure updates and changes to the waiver, fiscal processes and procedures and participant file and fiscal reviews. The SMA is involved with the Internal Waiver Review Committee on a quarterly basis when data and analysis regarding performance measures is presented and discussed. In addition to these more formal communications, the OA waiver manager and the SMA waiver contact have frequent and regular discussions regarding waiver operations.

## Appendix A: Waiver Administration and Operation

**3. Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

**Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

**No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

## Appendix A: Waiver Administration and Operation

**4. Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

**Not applicable**

**Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

**Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

*Specify the nature of these agencies and complete items A-5 and A-6:*

**Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

*Specify the nature of these entities and complete items A-5 and A-6:*

## Appendix A: Waiver Administration and Operation

- 5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

## Appendix A: Waiver Administration and Operation

- 6. Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

## Appendix A: Waiver Administration and Operation

- 7. Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency
Participant waiver enrollment		
Waiver enrollment managed against approved limits		
Waiver expenditures managed against approved levels		
Level of care evaluation		
Review of Participant service plans		
Prior authorization of waiver services		
Utilization management		
Qualified provider enrollment		
Execution of Medicaid provider agreements		
Establishment of a statewide rate methodology		
Rules, policies, procedures and information development governing the waiver program		
Quality assurance and quality improvement activities		

## Appendix A: Waiver Administration and Operation

### Quality Improvement: Administrative Authority of the Single State Medicaid

**Agency**

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

**a. Methods for Discovery: Administrative Authority**

*The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.*

**i. Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

*Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**The number and percent of waiver claims paid that were authorized via the ISP.**

**Numerator-The total number of claims paid that were authorized via the ISP.**

**Denominator-The total number of paid claims reviewed.**

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation(check each that applies):</b>	<b>Frequency of data collection/generation(check each that applies):</b>	<b>Sampling Approach(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; padding: 5px; margin-top: 10px;">             95% confidence level;              5% confidence interval           </div>

<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/>

**Performance Measure:**

The number and percent of unduplicated waiver participants that are maintained within approved waiver limits by operating agency. Numerator-The total number of unduplicated waiver participants enrolled each waiver year. Denominator-The total number of unduplicated participants approved in each waiver year.

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	<b>Annually</b>

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

**Performance Measure:**

**The number and percent of untimely ISP renewals that were appropriately and timely remediated. Numerator-The number of untimely annual ISP renewals appropriately remediated. Denominator-The total number of untimely annual ISPs.**

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> 95% confidence level;  5% confidence interval </div>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	<b>Other</b> Specify:	

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**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 250px; margin-top: 5px;"></div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 250px; margin-top: 5px;"></div>

**Performance Measure:**

The number and percent of providers enrolled by the operating agency according to policy.

**Numerator-**The total number of providers enrolled according to policy. **Denominator-**The total number of providers enrolled.

**Data Source** (Select one):**Presentation of policies or procedures**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =

<b>Other</b> Specify:  	<b>Annually</b>	<b>Stratified</b> Describe Group:  
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  
	<b>Other</b> Specify:  Upon enrollment of a new provider.	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
<b>Other</b> Specify:  	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  

**Performance Measure:**

The number and percent of provider rates established by the operating agency that are approved by the SSMA prior to implementation. Numerator-The number of provider rates established by the operating agency approved by the SSMA prior to implementation. Denominator-The total number of rates implemented.

**Data Source** (Select one):**Operating agency performance monitoring**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:	<b>Annually</b>

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="text"/>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

The number and percent of program policies developed by the operating agency that were approved by the SSMA prior to implementation. Numerator-The number of policies approved by SSMA prior to implementation. Denominator-The total number of policies implemented.

**Data Source** (Select one):**Operating agency performance monitoring**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>

	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 150px; margin-top: 5px;"></div>	
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**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 250px; margin-top: 5px;"></div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 250px; margin-top: 5px;"></div>

**Performance Measure:**

The number and percent of waiver expenditures that are maintained within approved waiver limits by operating agency. Numerator: The total waiver expenditures. Denominator: The total waiver expenditures approved in the waiver.

**Data Source** (Select one):**Operating agency performance monitoring**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b>

		Confidence Interval =  <input type="text"/>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/>

**Performance Measure:**

The number and percent of a statistically valid sample of participant records reviewed by

**the operating agency as required by the SSMA. Numerator-Total number of a statistically valid sample of participant records reviewed by the operating agency. Denominator: Total number of participant records that require review according to the sample.**

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;">             95% confidence level;              5% confidence interval           </div>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 150px; margin-top: 5px;"></div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div style="border: 1px solid black; height: 30px; width: 120px; margin-top: 5px;"></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 120px; margin-top: 5px;"></div>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 150px; margin-top: 5px;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The DHS/DDD implemented an online review system in 2011 to compile and calculate performance measures for the Family Support 360 waiver. At the time of development and implementation the DHS/DDD utilized a response distribution rate of 50% to ensure an appropriate sample size was achieved to set the required historical baseline as the review tool and methodologies had changed. After the initial year of baseline data the DHS/DDD utilizes the previous waiver year's review results to determine the appropriate distribution rate for the following waiver year. This process is fluid and has allowed the DHS/DDD to adjust the distribution rate according to the wealth of data contained within the online review system. The aforementioned system is known as the Systemic Monitoring and Reporting Technology (SMART) system. The SMART system allows the DDD to facilitate review of compliance with SSMA oversight of the performance of waiver functions. The SMART system aligns existing quality assurance and improvement processes with federal reporting requirements while concurrently producing meaningful information for systemic improvements.

The SMART system allows the DHS/DDD to review performance data related to Administrative Authority to monitor for individual remediation and systemic trends. The waiver manager is responsible for completing the aggregation and analysis of this information continuously and providing the analysis to the SSMA at least quarterly or more often as requested by the SSMA. The waiver manager presents the quality data to the SSMA during Internal Waiver Review Committee meetings. The SSMA can review waiver performance and corresponding data within the SMART system at any time as they have direct access to the system. Each error identified within the SMART system is remediated at an individual level and the data monitored for systemic issues. Ultimately, at the time the data is shared with the SSMA the errors and/or systemic issues have been addressed. The DDD is able to provide the SSMA remediation activities completed and necessary systemic adjustments completed. The SSMA provides additional direction as necessary to ensure compliance with the written waiver. In addition the data related to each of these performance measures is also presented quarterly to the Family Support Council.

The waiver manager conducts a quality assurance oversight review of all waiver participant enrollments and LOC evaluations to ensure procedures required by the SSMA are followed. If the waiver manager identifies a systemic issue within level of care determinations completed by DHS/DDD staff this information is shared with DDD management to be corrected as a performance issue. The waiver manager is also responsible to assure a statistically valid sample of waiver participant plans and waiver claims are reviewed and reported to the SSMA. The DHS/DDD manages waiver enrollment and expenditures against approved limits.

#### **b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on

the methods used by the state to document these items.

1) The waiver administrator, on a quarterly basis, will review the timeliness of all level of care determinations completed. If levels of care determinations are found to be outside the 45 day timeline the waiver administrator will determine the root cause for the delay. Upon determination of the root cause for the delay the waiver administrator will adjust internal DDD processes, provide training to DDD staff, or provide training to support coordinators/qualified providers. If it is discovered a LOC has not been completed the waiver administrator will complete the LOC within 3 business days. Training will be provided to DDD staff and support coordinators/qualified providers.

The waiver administrator will review claim reviews completed by DHS management analyst when completed. Based on the results of the claim reviews, if necessary, the waiver administrator will provide training to the Support Coordinator regarding the necessity for services being included in a participant's ISP prior to purchase of the service.

Annually the waiver administrator will query data systems to determine the number of approved unduplicated waiver participants and waiver funds expended. If it is identified that either of these areas are in excess of the approved waiver analysis will be completed to determine the cause. The waiver administrator will meet with the DHS/DDD director, director of DHS Budget and Finance to address. The DHS/DDD will meet with SSMA to determine appropriate actions which may include drafting of a waiver amendment for submission to CMS.

The waiver administrator is responsible for aggregation and analysis of the data quarterly. During review of the data the waiver administrator is responsible to ensure remediation has been completed. If it is discovered remediation has not been completed the waiver administrator will work directly with the DDD staff or support coordinator to ensure remediation completion. Additional training will be provided regarding the importance of ensuring remediation is completed at each individual case level. If the data indicates systemic issues the waiver administrator will determine necessary revisions to internal processes. The process changes will be approved by the SSMA and DHS/DDD management prior to implementation.

Quarterly the waiver administrator will review claims reviews completed by the DHS management analyst to ensure that all inappropriate claims have been remediated.

The waiver administrator is responsible to ensure program policies are reviewed and approved by the SSMA prior to implementation. If it is discovered this step in the process is missed the policy will be immediately provided to SSMA for review and approval. Adjustments to program policies will be made as directed by the SSMA and the new program policies provided to appropriate stake holders.

The waiver administrator is responsible for determination of the sample size of record reviews each waiver year. This is accomplished by utilizing historic review data available through the SMART system and applying a 95% confidence level and 5% confidence interval. The sample size is divided by 12 to determine the number of record reviews that must be completed each month. Quarterly, the waiver administrator reviews the total number of participant records reviewed to ensure the total number of required reviews will be achieved. If the waiver administrator determines the necessary number of records will not be achieved the total number of files reviewed in the subsequent months is increased. This will ensure the determined sample size of participant record reviews is achieved. The waiver manager provides this information to the SSMA quarterly.

The SSMA is highly involved within all these areas. Issues are identifiable during the process itself and remediated at that time.

## ii. Remediation Data Aggregation

### Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party( <i>check each that applies</i> ):	Frequency of data aggregation and analysis ( <i>check each that applies</i> ):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually

<b>Responsible Party</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

**No**

**Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix B: Participant Access and Eligibility

### B-1: Specification of the Waiver Target Group(s)

**a. Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<b>Aged or Disabled, or Both - General</b>					
		Aged		<input type="checkbox"/>	<input type="checkbox"/>
		Disabled (Physical)		<input type="checkbox"/>	<input type="checkbox"/>
		Disabled (Other)		<input type="checkbox"/>	<input type="checkbox"/>
<b>Aged or Disabled, or Both - Specific Recognized Subgroups</b>					
		Brain Injury		<input type="checkbox"/>	<input type="checkbox"/>
		HIV/AIDS		<input type="checkbox"/>	<input type="checkbox"/>
		Medically Fragile		<input type="checkbox"/>	<input type="checkbox"/>
		Technology Dependent		<input type="checkbox"/>	<input type="checkbox"/>
<b>Intellectual Disability or Developmental Disability, or Both</b>					
		Autism		<input type="checkbox"/>	<input type="checkbox"/>
		Developmental Disability	0	<input type="checkbox"/>	<input type="checkbox"/>
		Intellectual Disability	0	<input type="checkbox"/>	<input type="checkbox"/>
<b>Mental Illness</b>					

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
		Mental Illness			
		Serious Emotional Disturbance			

**b. Additional Criteria.** The state further specifies its target group(s) as follows:

Children living with natural, adopted, step-families or relatives who act in a parental capacity; adults living independently in the community; or adults living with a family member, legal guardian, or advocate.

**c. Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (*select one*):

**Not applicable. There is no maximum age limit**

**The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

*Specify:*

## Appendix B: Participant Access and Eligibility

### B-2: Individual Cost Limit (1 of 2)

**a. Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*). Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

**No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

**Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

**The limit specified by the state is (*select one*)**

**A level higher than 100% of the institutional average.**

Specify the percentage:

**Other**

*Specify:*

**Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete*

*Items B-2-b and B-2-c.*

**Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

*Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.*

**The cost limit specified by the state is (select one):**

**The following dollar amount:**

Specify dollar amount:

**The dollar amount (select one)**

**Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula:

**May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.**

**The following percentage that is less than 100% of the institutional average:**

Specify percent:

**Other:**

*Specify:*

## Appendix B: Participant Access and Eligibility

### B-2: Individual Cost Limit (2 of 2)

**Answers provided in Appendix B-2-a indicate that you do not need to complete this section.**

**b. Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

**c. Participant Safeguards.** When the state specifies an individual cost limit in Item B-2-a and there is a change in the

participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

**The participant is referred to another waiver that can accommodate the individual's needs.**

**Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

**Other safeguard(s)**

Specify:

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (1 of 4)

- a. Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	1422
Year 2	1502
Year 3	1582
Year 4	1622
Year 5	1742

- b. Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: (*select one*):

**The state does not limit the number of participants that it serves at any point in time during a waiver year.**

**The state limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 2	
Year 3	
Year 4	
Year 5	

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (2 of 4)

**c. Reserved Waiver Capacity.** The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State (*select one*):

**Not applicable. The state does not reserve capacity.**

**The state reserves capacity for the following purpose(s).**

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (3 of 4)

**d. Scheduled Phase-In or Phase-Out.** Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):

**The waiver is not subject to a phase-in or a phase-out schedule.**

**The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

**e. Allocation of Waiver Capacity.**

*Select one:*

**Waiver capacity is allocated/managed on a statewide basis.**

**Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

**f. Selection of Entrants to the Waiver.** Specify the policies that apply to the selection of individuals for entrance to the waiver:

If a waiting list develops, DDD will assign a level of priority for entrants to the waiver. The first level is "priority status" which is defined as individuals who are at a significant risk of institutionalization. All other individuals are placed in the second level, which is "applicant status. Significant risk means:

Individuals at imminent risk of being institutionalized;  
 Individuals who are institutionalized;  
 Individuals currently residing in an abusive, neglectful or exploitative situation; and  
 Individuals whose health, welfare or safety is in jeopardy.

Individuals in "priority status" will be placed at the top of the waiting list and receive services on a first come first serve basis. An individual who is at risk of abuse, neglect, or exploitation will be prioritized on the priority level list. A referral will be made to the Department of Social Services, Adult Services and Aging Division or Child Protection Services. Other programs will be explored through the Department of Social Services, Adult Services and Aging, Child Protection Services, and the Division of Developmental Disabilities. Individuals in applicant status will receive services on a first come first serve basis but after those in priority status.

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

## Appendix B: Participant Access and Eligibility

### B-4: Eligibility Groups Served in the Waiver

- a. **1. State Classification.** The state is a (*select one*):

§1634 State

SSI Criteria State

209(b) State

- 2. Miller Trust State.**

Indicate whether the state is a Miller Trust State (*select one*):

No

Yes

- b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply:*

**Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)**

Low income families with children as provided in §1931 of the Act

SSI recipients

Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121

Optional state supplement recipients

Optional categorically needy aged and/or disabled individuals who have income at:

*Select one:*

100% of the Federal poverty level (FPL)

% of FPL, which is lower than 100% of FPL.

Specify percentage:

Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in

**§1902(a)(10)(A)(ii)(XIII) of the Act)**

**Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**

**Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**

**Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**

**Medically needy in 209(b) States (42 CFR §435.330)**

**Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

**Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

*Specify:*

---

*Special home and community-based waiver group under 42 CFR §435.217) Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

---

**No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.**

**Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

*Select one and complete Appendix B-5.*

**All individuals in the special home and community-based waiver group under 42 CFR §435.217**

**Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

*Check each that applies:*

**A special income level equal to:**

*Select one:*

**300% of the SSI Federal Benefit Rate (FBR)**

**A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

**A dollar amount which is lower than 300%.**

Specify dollar amount:

**Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

**Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

**Medically needy without spend down in 209(b) States (42 CFR §435.330)**

**Aged and disabled individuals who have income at:**

*Select one:*

**100% of FPL****% of FPL, which is lower than 100%.**Specify percentage amount: **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (1 of 7)

*In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.*

- a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

*Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.*

**Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**

*Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).*

*Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).*

**Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the state elects to (*select one*):

**Use spousal post-eligibility rules under §1924 of the Act.**

*(Complete Item B-5-b (SSI State) and Item B-5-d)*

**Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**

*(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)*

**Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**

*(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)*

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (2 of 7)

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.*

- b. Regular Post-Eligibility Treatment of Income: SSI State.**

The state uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

---

**i. Allowance for the needs of the waiver participant** (*select one*):

---

**The following standard included under the state plan**

*Select one:*

**SSI standard**

**Optional state supplement standard**

**Medically needy income standard**

**The special income level for institutionalized persons**

(*select one*):

**300% of the SSI Federal Benefit Rate (FBR)**

**A percentage of the FBR, which is less than 300%**

Specify the percentage:

**A dollar amount which is less than 300%.**

Specify dollar amount:

**A percentage of the Federal poverty level**

Specify percentage:

**Other standard included under the state Plan**

*Specify:*

**The following dollar amount**

Specify dollar amount:  If this amount changes, this item will be revised.

**The following formula is used to determine the needs allowance:**

*Specify:*

**Other**

*Specify:*



---

**ii. Allowance for the spouse only** (*select one*):

---

**Not Applicable**

**The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

*Specify:*

**Specify the amount of the allowance (*select one*):**

**SSI standard**

**Optional state supplement standard**

**Medically needy income standard**

**The following dollar amount:**

Specify dollar amount:  If this amount changes, this item will be revised.

**The amount is determined using the following formula:**

*Specify:*



---

**iii. Allowance for the family (*select one*):**

---

**Not Applicable (see instructions)**

**AFDC need standard**

**Medically needy income standard**

**The following dollar amount:**

Specify dollar amount:  The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

**The amount is determined using the following formula:**

*Specify:*

**Other**

*Specify:*



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**iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:**

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- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's

Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

**Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

**The state does not establish reasonable limits.**

**The state establishes the following reasonable limits**

*Specify:*

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (3 of 7)

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.*

#### c. Regular Post-Eligibility Treatment of Income: 209(B) State.

**Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.**

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (4 of 7)

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.*

#### d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

##### i. Allowance for the personal needs of the waiver participant

*(select one):*

**SSI standard**

**Optional state supplement standard**

**Medically needy income standard**

**The special income level for institutionalized persons**

**A percentage of the Federal poverty level**

Specify percentage:

**The following dollar amount:**

Specify dollar amount:  If this amount changes, this item will be revised

**The following formula is used to determine the needs allowance:**

*Specify formula:*

**Other***Specify:*

 300% of SSI Federal Benefit Rate in addition to any and all money placed in a Miller Trust.

- ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.**

Select one:

**Allowance is the same****Allowance is different.***Explanation of difference:*


- iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:**

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

**Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

**The state does not establish reasonable limits.****The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

## Appendix B: Participant Access and Eligibility

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### B-5: Post-Eligibility Treatment of Income (5 of 7)

*Note: The following selections apply for the five-year period beginning January 1, 2014.*

**e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.**

**Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.**

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## Appendix B: Participant Access and Eligibility

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### B-5: Post-Eligibility Treatment of Income (6 of 7)

*Note: The following selections apply for the five-year period beginning January 1, 2014.*

**f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.**

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Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

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## Appendix B: Participant Access and Eligibility

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### B-5: Post-Eligibility Treatment of Income (7 of 7)

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*Note: The following selections apply for the five-year period beginning January 1, 2014.*

#### **g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.**

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

---

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

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## Appendix B: Participant Access and Eligibility

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### B-6: Evaluation/Reevaluation of Level of Care

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*As specified in 42 CFR §441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.*

**a. Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

#### **i. Minimum number of services.**

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is:

#### **ii. Frequency of services.** The state requires (select one):

**The provision of waiver services at least monthly**

**Monthly monitoring of the individual when services are furnished on a less than monthly basis**

*If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:*

**b. Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (*select one*):

**Directly by the Medicaid agency**

**By the operating agency specified in Appendix A**

**By a government agency under contract with the Medicaid agency.**

*Specify the entity:*

**Other***Specify:*

- c. Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

The initial level of care evaluation is conducted by the DDD Qualified Intellectual Disability Professional (QIDP) as specified in 42 CFR 483.430 (a) or a qualified DHS/DDD staff. The QIDP has at least one year experience working directly with people with an intellectual disability or other developmental disability and holds at least a bachelor's degree in a professional category or a DHS/DDD Program Specialist that has five years of equivalent training and work experience AND knowledge of the public service system for ID/DD in South Dakota.

- d. Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The criteria for entrance into an ICF/IID are as follows:

- \* The individual must be developmentally disabled as defined in 67:54:03:03 (criteria for determining developmental disability); and
- \* The utilization review team must have determined that the individual is in need of ICF/IID services pursuant to 67:54:03:04 (determination of need for ICF/IID services).

The Level of Care criteria used to evaluate whether an individual needs HCB waiver services are:

- \* Birth to Three Assessment for children under age 3;
- \* Inventory for Client and Agency Planning (ICAP) eligibility for those individuals age 4 and above with a minimum of 3 functional limitations;
- \* Service Plan;
- \* Psychological or psycho educational evaluation;
- \* DHS-DD717 Form HCB Waiver Rights - Used to inform the person that services are available from the Home and Community Based Services Waiver. Each person is provided with a list of HCBS providers; informed of the appeal process for denial of services if the person is determined not eligible; and provided with contact information to request a fair hearing.

The Level of Care criteria used to reevaluate whether a participant has a continued need for HCB waiver services includes;

- \* Birth to Three Assessment for children under age 3
- \* ICAP eligibility for those participant's age 4 and above with a minimum of 3 functional limitations.

- e. Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):

**The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**

**A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

**f. Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The process used for evaluating/reevaluating the level of care for waiver participants is as follows:

**Initial Evaluation:**

The support coordinator gathers all forms and information listed below and submits to DDD for initial evaluation.

- Birth to Three Assessment for children under age 3;
- ICAP eligibility for those individuals age 4 and above with a minimum of 3 functional limitations;
- DHS-DD717 Form HCBS Waiver Rights - Used to inform the person that services are available from the Home and Community Based Services Waiver. Each person is provided with a list of HCBS providers, informed of the appeal process for denial of services if the person is determined not eligible, and provided with contact information to request a fair hearing;
- Service Plan; and
- Psychological or psycho-educational evaluation.

Once all required documentation is received by the DHS/DDD a QIDP or qualified DHS/DDD staff determines initial eligibility. Once an initial eligibility determination has been made the QIDP or qualified DHS/DDD staff completes the DD730 form which provides the SSMA with a recommendation for eligibility along with a recommended effective date of initial eligibility.

**Re-evaluation:**

Re-evaluation is performed annually. The Level of Care criteria used to reevaluate whether an individual has a continued need for HCB waiver services are assessed by a QIDP or qualified DDD staff. The documentation reviewed annually includes:

- Birth to Three Assessment for children under age 3;
- Psycho-educational evaluation; or
- ICAP eligibility for those individual's age 4 and above with a minimum of 3 functional limitations.

**g. Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):

**Every three months**

**Every six months**

**Every twelve months**

**Other schedule**

*Specify the other schedule:*

**h. Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations (*select one*):

**The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**

**The qualifications are different.**

*Specify the qualifications:*

- i. Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care (*specify*):

DHS/DDD completes reevaluations of participants' level of care annually based on each participant's current ICAP, psycho-educational evaluation or Birth to Three evaluation. Reevaluation information is submitted to the DHS/DDD by the support coordinator annually for each waiver participant. The DHS/DDD conducts the reevaluation for each waiver participant. This process is completed on a staggered basis during the months of June-August. The operating agency provides a reminder notification to each support coordinator in March of each waiver year regarding the month reevaluations for waiver participants they work with will be completed. This allows sufficient time to gather and submit documentation necessary for the reevaluation to be completed. To ensure this process is completed within 12 months of the previous reevaluation the waiver participants are reevaluated within the same month as the previous year. If information is not received by the appropriate parties by the specified date, they are contacted and required to submit the information within 3 business days.

- j. Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The support coordinator maintains these records. A copy is retained at the DHS/DDD State Office.

## Appendix B: Evaluation/Reevaluation of Level of Care

### Quality Improvement: Level of Care

*As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.*

#### **a. Methods for Discovery: Level of Care Assurance/Sub-assurances**

*The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.*

##### **i. Sub-Assurances:**

- a. Sub-assurance:** *An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.*

##### **Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

##### **Performance Measure:**

**The percentage of new participants who had a level of care completed prior to the initiation of services. Numerator-The number of new participants to the waiver with**

**a level of care completed prior to initiation of services/Denominator-Total number of new participants.**

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

- b. Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.**

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

- c. Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.**

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**The number and percent of level of care determinations made where the level of care criteria was accurately applied. Numerator - The number of participant level of care determinations where criteria was accurately applied. Denominator - The total number of level of care determinations completed.**

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b>	<b>Annually</b>

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

**Performance Measure:**

The number and percent of participants whose level of care determination contained the required documentation. Numerator-The number of level of care determinations completed with correct documentation. Denominator - Total number of level of care determinations completed.

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:

		<input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

The number and percent of level of care determinations completed by the operating agency within 45 days. Numerator-The number of level of care determinations completed within 45 days. Denominator-The total number of level of care determinations completed.

**Data Source** (Select one):

**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
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<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
	<b>Other</b> Specify: <div></div>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The DHS/DDD implemented an online review system in 2011 to compile and calculate performance measures for the Family Support 360 waiver. At the time of development and implementation the DHS/DDD utilized a response distribution rate of 50% to ensure an appropriate sample size was achieved to set the required historical baseline as the review tool and methodologies had changed. After the initial year of baseline data the DHS/DDD utilizes the previous waiver year's review results to determine the appropriate distribution rate for the following waiver year. This process is fluid and has allowed the DHS/DDD to adjust the distribution rate according to the wealth of data contained within the online review system. The aforementioned system is known as the Systemic Monitoring and Reporting Technology (SMART) system. The SMART system allows the DDD to facilitate review of compliance with SSMA oversight of the performance of waiver functions. The SMART system aligns existing quality assurance and improvement processes with federal reporting requirements while concurrently producing meaningful information for systemic improvements.

The SMART system allows the DHS/DDD to review performance data related to waiver participant level of care activities for individual remediation and systemic trends. The waiver administrator is responsible for completing the aggregation and analysis of this information continuously and providing the analysis to the SSMA at least quarterly or more often as requested by the SSMA. The waiver administrator presents the quality data to the SSMA during Internal Waiver Review Committee meetings. The SSMA can review waiver performance and corresponding data within the SMART system at any time as they have direct access to the system. Each error identified within the SMART system is remediated at an individual level and the data monitored for systemic issues. Ultimately, at the time the data is shared with the SSMA the errors and/or systemic issues have been addressed. The SSMA provides additional direction as necessary to ensure compliance with the written waiver. In addition the data related to each of these performance measures is also presented to the Family Support Council as requested.

The waiver administrator is responsible for aggregating quarterly and annual data for remediation by the SSMA and the IWRC. The SSMA, Family Support Council and the IWRC monitors performance measures related to the timeliness of initial LOC determinations and the accuracy of initial determinations. LOC determinations are made by DHS/DDD QIDP or a qualified DHS/DDD staff who may request clinical consultation on difficult determinations.

Annual redeterminations are completed by the DHS/DDD on a staggered basis annually between June and August each year. All waiver participant redeterminations are completed during this timeframe. The redeterminations are made by a QIDP or qualified DHS/DDD staff.

The primary discovery activities that have the potential to reveal individual problems related to level of care include complaint referrals to DHS/DDD, LOC reviews, administrative hearing requests contesting ineligibility, and public forums. When an individual problem is discovered, DHS/DDD takes immediate action to assess, and if necessary, ensure the safety of the individual and other waiver participants. The waiver administrator or Program Specialist, or a Family Support Coordinator may be assigned to meet with the individual to provide additional support in completing and/or gathering information critical to the determination process. The problem would be documented and systemically remediated through the discovery activity that revealed the problem. If the individual has or is requesting a LOC determination, the problem may also be documented in the individual's case file.

## **b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

A-1) If it is discovered that a participant has received waiver services prior to an approved level of care the DHS/DDD will immediately ensure that any claims have been denied. The waiver administrator will immediately ensure the completion of a LOC to determine the participant's eligibility status and conduct training with the Family Support Coordinator. If the level of care determination indicates the person is not eligible for waiver services this information is sent to the SSMA. The SSMA provides the person with their right to appeal. The person is referred to additional community resources they may be eligible for.

C-1 and C-2) The waiver administrator conducts a quality assurance review of 100% of initial level of care decision. If an initial level of care decision, either approval or denial, is found to be incorrect this is remediated on a case by case basis. The identified portion of the process or inappropriate application of the instrument is identified and immediately corrected. If this results in a waiver participant no longer meeting eligibility criteria for the waiver this information is sent to the SSMA. The SSMA provides the person with their right to appeal. The person is referred to additional community resources they may be eligible for. Any payments that may have been made for waiver services will require claim adjustments be completed. If the process or application of the instrument resulted in a determination of ineligibility and the review shows the person is eligible, their LOC would be considered complete and they are immediately contacted and waiver services are started. Additional training is provided on a case by case basis to the person who made the incorrect level of care determination.

## ii. Remediation Data Aggregation

### Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party( <i>check each that applies</i> ):	Frequency of data aggregation and analysis ( <i>check each that applies</i> ):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div></div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

## c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix B: Participant Access and Eligibility

### B-7: Freedom of Choice

**Freedom of Choice.** As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care

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for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and
- ii. given the choice of either institutional or home and community-based services.

- a. Procedures.** Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Choice and Rights of participants served under HCBS is afforded to them and their families at the initiation of services. DDD has a Choice and Rights form, DD 717, that is used by support coordinators to inform participants that services are available from the Home and Community Based Waiver or from an institutional level of care. The participant is also provided with a list of all HCBS providers in South Dakota. This document explains HCBS to participants and informs them that they have a right to appeal the decision of ineligibility if they are found ineligible for HCBS.

- b. Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The support coordinator maintains these records and a copy is retained at the DHS/DDD state office.

## Appendix B: Participant Access and Eligibility

### B-8: Access to Services by Limited English Proficiency Persons

**Access to Services by Limited English Proficient Persons.** Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

Support coordinators will contract with interpreters to provide service to Limited English Proficient Persons who receive waiver services. All forms and materials will be translated to each persons language. Support coordinators will refer participants to English classes within each persons city to increase English proficiency. The DHS/DDD also has access to interpretation services to ensure meaningful conversations are able to be had with waiver participants, family members, and guardians of limited English proficient persons.

## Appendix C: Participant Services

### C-1: Summary of Services Covered (1 of 2)

- a. Waiver Services Summary.** List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service		
Statutory Service	Personal Care 1		
Statutory Service	Respite		
Statutory Service	Support Coordination		
Statutory Service	Supported Employment		
Extended State Plan Service	Personal Care 2		
Other Service	Companion Care		
Other Service	Environmental accessibility adaptations, (a.k.a., EAA)		
Other Service	Nutritional Supplements		
Other Service	Specialized Medical Adaptive Equipment and Supplies (a.k.a., SMAES)		
Other Service	Specialized Therapies		
Other Service	Vehicle Modification		

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Statutory Service

**Service:**

Personal Care

**Alternate Service Title (if any):**

Personal Care 1

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

The Family Support 360 waiver's Personal Care 1 service provides a range of assistance to enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a disability, including assistance with eating, bathing, personal hygiene, and activities of daily living. This service may include assistance with preparation of meals, but does not include the cost of meals themselves. When specified in the plan of care this service may also include such housekeeping chores as bedmaking, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the participant, rather than the participants family. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing/prompting the participant to perform a task.

Personal care services may be provided on an episodic or on a continuing basis. Frequency or intensity of personal care is provided as indicated in the service plan.

Because Personal Care 1 services in the waiver differ in supervision arrangements (including training), provider type, Family Support 360 waiver participants are not required to access State Plan services prior to accessing services through the waiver. Additionally, waiver participants are not required to have a physician order to access Personal Care 1 services available through the waiver. The State Plan requires a physician order.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Personal Care 1 services do not duplicate the State Plan personal care plan service as the Personal Care 1 services provided through the Family Support 360 waiver differ in supervision arrangements and provider type. The waiver services offer participant direction through an Agency With Choice Model as described in Appendix E. Additionally, waiver participants are not required to have a physician order to access Personal Care 1 services available through the waiver. The State Plan requires a physician order. Qualified providers of waiver services are Community Support Providers and other qualified providers designated by the Department of Human Services as described in Appendix C. The State Plan services do not offer participant direction opportunities in the provision of personal care. Qualified providers of personal care under the State Plan are limited as prescribed in ARSD 67:67:05.01 to "Home health agency," an organization which is primarily engaged in providing skilled nursing, medical social services, or home health aide services and which meets the requirements of a home health agency under 42 C.F.R. § 405.1201 (October 1, 1988). To avoid duplication of services, including companion care, the support coordinator reviews the individual service plan to ensure the services reflect the goals described in the plan. Additionally, if the waiver participant's service plan list personal care services that appear to be another waiver service, for example companion care, the personal care waiver service will be reviewed closely. If the services being delivered are not personal care services the state will contact the support coordinator to explain the need to change the waiver service. The support coordinator will be responsible to contact the family to discuss and upon agreement the waiver participant's service plan will be updated to reflect the correct waiver service.

**Service Delivery Method** (*check each that applies*):

**Participant-directed as specified in Appendix E**

**Provider managed**

**Specify whether the service may be provided by** (*check each that applies*):

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Provider of Personal Care 1
Agency	Community Support Provider

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

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**Service Type: Statutory Service**
**Service Name: Personal Care 1**


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**Provider Category:**

**Provider Type:**

**Provider Qualifications****License** (*specify*):
**Certificate** (*specify*):
**Other Standard** (*specify*):

Adult Day Services Agency-designated by Division of Developmental Disabilities as a qualified Personal Care 1 provider  
 Non-medical In-home Care Agency-designated by Division of Developmental Disabilities as a qualified Personal Care 1 provider

The qualified Personal Care 1 provider must meet the following criteria:

1. Have a signed provider agreement with the Division of Developmental Disabilities
2. Have a signed provider agreement with the Department of Social Services
3. Agency employees must meet the following qualifications:
  - a. Be at least 18 years of age unless there is an occasion when a qualified provider at least 18 years is not available. On those occasions, the provider must be at least 16 years old.
  - b. Pass a criminal background check
  - c. Be able to follow written or verbal instructions provided by the participant, guardian, advocate, or family member of the participant; and
  - d. Have the abilities or skills necessary as determined by the participant to meet the participant's needs as outlined in the ISP; and
4. Have policies in the following areas:
  - a. Confidentiality
  - b. Drug-free workplace
  - c. Grievance
  - d. Emergency procedures and back-up plan
  - e. Sexual harassment
  - f. Abuse, neglect, exploitation
  - g. Safety
  - h. Universal precautions
  - i. Termination and notice requirements
  - j. Payment and billing

Oversight of the agency employee will be provided by the participant or legal guardian, advocate or family member of the participant. The agency employee will receive training as indicated in the service plan which is commensurate with the service or support to be provided, from the participant or legal guardian, advocate or family member of the participant in performance of all Personal Care 1 services delineated in the service plan. Specific areas of training and who will provide the training will be documented in the service plan.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

**Frequency of Verification:**

Adult Day Services Agency- Annually  
Non-medical In-home Care Agency- Annually

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Personal Care 1****Provider Category:**

Agency

**Provider Type:**

Community Support Provider

**Provider Qualifications****License** (*specify*):

Not applicable.

**Certificate** (*specify*):

A CSP must be certified by the Division pursuant to Administrative Rules of South Dakota (ARSD) 46:11:02. The CSP must be an enrolled medicaid provider and have a provider agreement with DDD.

**Other Standard** (*specify*):

The Personal Care 1 provider will be at least 18 years of age unless there is an occasion when a qualified provider at least 18 years is not available. On those occasions, the provider must be at least 16 years old.

Oversight of the agency employee will be provided by the consumer or legal guardian, advocate or family member of the participant. The personal care provider will be able to follow written or verbal instructions given by the participant or legal guardian, advocate or family member of the participant and have the ability or skills necessary to meet the participants needs as delineated in the service plan. The personal care provider will receive training as indicated in the service plan which is commensurate with the service or support to be provided, from the participant or legal guardian, advocate or family member of the participant in performance of all Personal Care 1 services delineated in the service plan. Specific areas of training and who will provide the training will be documented in the service plan.

The AWC model does require employees to undergo a background check and the needed training for the service provided. The participant or the managing employer trains the provider also on specific needs and services that the participant will require.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

DDD verifies qualified provider status on a biennial basis. Qualified providers have the responsibility of verifying Personal Care 1 provider age at time of hire. Support coordinators and families/participants have the responsibility of monitoring the service plan to ensure the provision of training and skills of the Personal Care 1 provider.

**Frequency of Verification:**

See "entity responsible for verification."

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Statutory Service

**Service:**

Respite

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

Respite care services are provided to assist participants unable to care for themselves, furnished on a frequency as determined in the service plan because of the absence or need for relief of those persons normally providing the care. Respite will be provided intermittently on a temporary basis.

FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence. Respite care can be provided in the following locations:

- 1) Participants home or place of residence;
- 2) Foster Home;
- 3) Medicaid certified hospital;
- 4) Medicaid certified ICF/IID;
- 5) Group home;
- 6) A home approved in the plan of care, which may be a private residence; or
- 7) Other community care residential facility approved by the State that is not a private residence, such as a licensed day care.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Respite care will not be provided for more than 30 consecutive days.

**Service Delivery Method** (*check each that applies*):

**Participant-directed as specified in Appendix E**

**Provider managed**

**Specify whether the service may be provided by** (*check each that applies*):

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Community Support Provider
Agency	Provider of Respite Care

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Community Support Provider

**Provider Qualifications**

**License** (*specify*):

Not applicable.

**Certificate** (*specify*):

A CSP must be certified by the Division pursuant to Administrative Rules of South Dakota (ARSD) 46:11:02. The CSP must be an enrolled medicaid provider and have a provider agreement with DDD.

**Other Standard** (*specify*):

The respite care provider will be at least 16 years of age.

Oversight of the agency employee will be provided by the participant or legal guardian, advocate or family member of the participant. The respite care provider will be able to follow written or verbal instructions given by the participant or legal guardian, advocate or family member of the participant and have the ability or skills necessary to meet the participants needs as delineated in the service plan. The provider will receive training as indicated in the service plan which is commensurate with the service or support to be provided, from the participant or legal guardian, advocate or family member of the participant in performance of all respite care services delineated in the service plan. Specific areas of training and who will provide the training will be documented in the service plan.

The AWC model does require employees to undergo a background check and the needed training for the service provided. The participant or the managing employer trains the provider also on specific needs and services that the participant will require.

### Verification of Provider Qualifications

#### Entity Responsible for Verification:

DDD verifies qualified provider status on an biennial basis. Qualified providers have the responsibility of verifying respite care provider age at time of hire. Support coordinators and families/participants have the responsibility of monitoring the service plan to ensure the provision of training and skills of the respite care provider

#### Frequency of Verification:

See "entity responsible for verification."

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**

**Service Name: Respite**

#### Provider Category:

Agency

#### Provider Type:

Provider of Respite Care

#### Provider Qualifications

##### License (specify):

Childcare Home- Licensed by Department of Social Services pursuant to ARSD 67:42:04  
 Childcare Center-Licensed by Department of Social Services pursuant to ARSD 67:42:10  
 Before and After School Care Center-Licensed by Department of Social Services pursuant to 67:42:14  
 Nursing Facility-Licensed by Department of Health pursuant to SDCL 34-12-2, ARSD 44:04  
 Hospital-Licensed by Department of Health pursuant to SDCL 34-12-2, ARSD 44:04  
 Foster Care Home-Licensed by Department of Social Services pursuant to 67:42:05

##### Certificate (specify):

Not applicable.

##### Other Standard (specify):

Adult Day Services Agency-Designated by Division of Developmental Disabilities as a qualified provider of Respite Care

The qualified Respite Care provider must meet the following criteria:

1. Have a signed provider agreement with the Division of Developmental Disabilities
2. Have a signed provider agreement with the Department of Social Services
3. Agency employees must meet the following qualifications:
  - a. Be at least 16 years of age;
  - b. Pass a criminal background check;
  - c. Be able to follow written or verbal instructions provided by the participant, guardian, advocate, or family member of the participant; and
  - d. Have the abilities or skills necessary as determined by the participant to meet the participant's needs as outlined in the ISP; and
4. Have policies in the following areas:
  - a. Confidentiality
  - b. Drug-free workplace
  - c. Grievance
  - d. Emergency procedures and back-up plan
  - e. Sexual harassment
  - f. Abuse, neglect, exploitation
  - g. Safety
  - h. Universal precautions
  - i. Termination and notice requirements
  - j. Payment and billing

Oversight of the agency employee will be provided by the participant or legal guardian, advocate or family member of the participant. The provider will receive training as indicated in the service plan which is commensurate with the service or support to be provided, from the participant or legal guardian, advocate or family member of the participant in performance of all respite care services delineated in the service plan. Specific areas of training and who will provide the training will be documented in the service plan.

#### **Verification of Provider Qualifications**

##### **Entity Responsible for Verification:**

Childcare Home- Department of Social Services  
 Childcare Center-Department of Social Services  
 Before and After School Care Center-Department of Social Services  
 Nursing Facility- Department of Health  
 Hospital-Department of Health  
 Foster Care Home-Department of Social Services  
 Adult Day Services Agency-Division of Developmental Disabilities

##### **Frequency of Verification:**

Childcare Home- Annually  
 Childcare Center-Annually  
 Before and After School Care Center-Annually  
 Nursing Facility-Annually  
 Hospital-Schedule dictated by Department of Health  
 Foster Care Home-Annually  
 Adult Day Services Agency-Annually

## **Appendix C: Participant Services**

**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

**Service:**

**Alternate Service Title (if any):**

**HCBS Taxonomy:****Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**


Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

Services provided to assist participants who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained. Support coordinators shall be responsible for ongoing monitoring of the provision of services included in the individuals service plan. Support coordinators shall initiate and oversee the process of assessment and reassessment of the individuals level of care and the review of service plans at such intervals.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

**Service Delivery Method (check each that applies):**

**Participant-directed as specified in Appendix E**

**Provider managed**

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Support Provider

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Support Coordination

Provider Category:

Agency

Provider Type:

Community Support Provider

Provider Qualifications

License (specify):

Not applicable.

Certificate (specify):

A CSP must be certified by the Division pursuant to Administrative Rules of South Dakota (ARSD) 46:11:02. The CSP must be an enrolled medicaid provider and have a provider agreement with DDD.

Other Standard (specify):

The support coordinator will have a degree in the field of human services, social work, sociology, psychology, or related field experience and /or be a parent of a child with a developmental disability. The support coordinator must have the ability to communicate in writing and verbally, to work independently once training is completed, and effectively utilize computer skill in Word, Access and the Internet.

The support coordinator will complete the following training: Administration of the HCBS Family Support Waiver; Plan of Care Development; State Plan Services; defining, identifying and reporting abuse, neglect, and exploitation; IEP Process; defining Developmental Disability; and ICAP Training. The support coordinator who is a parent of a child with a developmental disability will not provide support coordination to his or her own child and will complete the same training identified above.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS/DDD verifies qualified provider status on an biennial basis. Qualified providers have the responsibility of verifying support coordinator qualifications at the time of hire. Qualified providers and families/participants monitor ongoing performance.

Frequency of Verification:

See "entity responsible for verification."

**Appendix C: Participant Services****C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:****Service:****Alternate Service Title (if any):****HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

Supported Employment services consist of intensive, ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports to perform in a regular work setting. Supported Employment may include assisting the participant to locate a job or develop a job on behalf of the participant. Supported Employment is conducted in a variety of settings, particularly work sites where persons without disabilities are employed. Supported Employment includes activities needed to sustain paid work by participants, including supervision and training. When Supported Employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by participants receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported Employment services are directed towards assisting participants to obtain and retain paid employment in community settings. These services are job finding and job placement activities, situational evaluations and trial placements, instruction for participants, co-workers and employers to assist participants to transition to work in an integrated setting; and long-term support to help participants maintain a desired, integrated employment status.

Supported Employment services do not include production of goods or services, nor compensation of participants served.

Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

**Service Delivery Method** (*check each that applies*):

**Participant-directed as specified in Appendix E**

**Provider managed**

**Specify whether the service may be provided by** (*check each that applies*):

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Provider of Supported Employment
Agency	Community Support Provider

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**

**Service Name: Supported Employment**

**Provider Category:**

Agency

**Provider Type:**

Provider of Supported Employment

**Provider Qualifications**

**License** (*specify*):

Not applicable.

**Certificate** (*specify*):

Not applicable.

**Other Standard** (*specify*):

Supported Employment Agency-Designated by Division of Developmental Disabilities as a qualified provider of Supported Employment.

The qualified Supported Employment provider must meet the following criteria:

1. Have a signed provider agreement with the Division of Developmental Disabilities
2. Have a signed provider agreement with the Department of Social Services
3. All employees must meet the following qualifications:
  - a. Be at least 18 years of age;
  - b. Pass a criminal background check;
  - c. Be able to follow written or verbal instructions provided by the participant, guardian, advocate, or family member of the participant;
  - d. Have the abilities or skills necessary as determined by the participant to meet the participant's needs as outlined in the ISP; and
4. Have policies in the following areas:
  - a. Confidentiality
  - b. Drug-free workplace
  - c. Grievance
  - d. Emergency procedures and back-up plan
  - e. Sexual harassment
  - f. Abuse, neglect, exploitation
  - g. Safety
  - h. Universal precautions
  - i. Termination and notice requirements
  - j. Payment and billing

Oversight of the agency employee will be provided by the participant or legal guardian, advocate or family member of the participant and/or the support Coordinator. The provider will receive training as indicated in the service plan which is commensurate with the service or support to be provided, from the participant or legal guardian, advocate or family member of the participant in performance of all supported employment services delineated in the service plan. The supported employment agency employee will maintain confidentiality and complete required record keeping.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Division of Developmental Disabilities

**Frequency of Verification:**

Annually

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type:** Statutory Service**Service Name:** Supported Employment**Provider Category:**

Agency

**Provider Type:**

Community Support Provider

**Provider Qualifications****License** (*specify*):

Not applicable.

**Certificate** (*specify*):

A CSP must be certified by the Division pursuant to Administrative Rules of South Dakota (ARSD) 46:11:02. The CSP must be an enrolled medicaid provider and have a provider agreement with DDD.

**Other Standard** (*specify*):

Oversight of the agency employee will be provided by the participant or legal guardian, advocate or family member of the participant and/or the Support Coordinator. The agency employee will be able to follow written or verbal instructions given by the participant or legal guardian, advocate or family member of the participant and have the ability or skills necessary to meet the participants needs as delineated in the service plan. The agency employee will receive training as indicated in the service plan which is commensurate with the service or support to be provided, from the participant or legal guardian, advocate or family member of the participant in performance of all supported employment services delineated in the service plan. The supported employment agency employee will maintain confidentiality and complete required record keeping. The agency employee will be at least 18 years of age.

The AWC model does require agency employees to undergo a background check and the needed training for the service provided. The participant or the managing employer trains the provider on specific needs and services that the participant will require.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

DDD verifies qualified provider status on a biennial basis. Qualified providers have the responsibility of verifying supported employment agency employee age at time of hire. Support coordinators and families/participants have the responsibility of monitoring the plan of care to ensure the provision of training and skills of the supported employment agency employee.

**Frequency of Verification:**

See "entity responsible for verification."

**Appendix C: Participant Services****C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Extended State Plan Service

**Service Title:**

Personal Care 2

**HCBS Taxonomy:****Category 1:**

08 Home-Based Services

**Sub-Category 1:**

08030 personal care

**Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

A range of assistance is provided to enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a disability, including assistance with eating, bathing, personal hygiene, and activities of daily living. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing/prompting the participant to perform a task. Personal Care 2 services may be provided on an episodic or on a continuing basis. Frequency or intensity of Personal Care 2 is provided as indicated in the approved service plan.

Personal Care 2 services provided through the Family Support waiver can enhance the amount, duration or frequency of the State Plan service. Qualified providers of personal care under the State Plan are limited as prescribed in ARSD 67:16:05:01 to "Home health agency," an organization which is primarily engaged in providing skilled nursing, medical social services, or home health aide services and which meets the requirements of a home health agency under 42 C.F.R. § 405.1201 (October 1, 2005). The amount of Personal Care 2 services chargeable as waiver services is the amount incurred after any limits in State Plan services through the Home Health agency are exhausted. Frequency or intensity of Personal Care 2 is provided as indicated in the approved service plan.

This service is not available to individuals who are eligible to receive such service through the Medicaid State Plan (including EPSDT benefits).

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Not applicable.

**Service Delivery Method (check each that applies):**

**Participant-directed as specified in Appendix E**

**Provider managed**

**Specify whether the service may be provided by (check each that applies):**

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Home Health Care Agency

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Extended State Plan Service**

**Service Name: Personal Care 2**

**Provider Category:**

Agency

**Provider Type:**

Home Health Care Agency

**Provider Qualifications**

**License** (*specify*):

Not applicable.

**Certificate** (*specify*):

Not applicable.

**Other Standard** (*specify*):

Home Health Agency-designated by Division of Developmental Disabilities as a qualified Personal Care 2 provider

The qualified Personal Care 2 provider must meet the following criteria:

1. Have a signed provider agreement with the Division of Developmental Disabilities
2. Have a signed provider agreement with the Department of Social Services
3. Agency employees must meet the following qualifications:
  - a. Be at least 18 years of age unless there is an occasion when a qualified provider at least 18 years is not available. On those occasions, the provider must be at least 16 years old.
  - b. Pass a criminal background check
  - c. Be able to follow written or verbal instructions provided by the participant, guardian, advocate, or family member of the participant; and
  - d. Have the abilities or skills necessary as determined by the participant to meet the participant's needs as outlined in the ISP; and
4. Have policies in the following areas:
  - a. Confidentiality
  - b. Drug-free workplace
  - c. Grievance
  - d. Emergency procedures and back-up plan
  - e. Sexual harassment
  - f. Abuse, neglect, exploitation
  - g. Safety
  - h. Universal precautions
  - i. Termination and notice requirements
  - j. Payment and billing

The agency employee will receive training as indicated in the service plan which is commensurate with the service or support to be provided, from the participant or legal guardian, advocate or family member of the participant in performance of all Personal Care 2 services delineated in the service plan. Specific areas of training and who will provide the training will be documented in the service plan.

#### Verification of Provider Qualifications

##### Entity Responsible for Verification:

DHS/DDD

##### Frequency of Verification:

Annually

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

#### Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

#### Service Title:

Companion Care

**HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

Companion services are non-medical and include supervised integrated socialization, role modeling, and independent living skill development. Skill development may include such tasks as assistance and/or supervision of meal preparation, laundry and shopping, navigation of public transportation, assistance and/or supervision with acquisition, retention or improvement in self help, socialization, and adaptive skills. This may take the form of hands-on assistance or cuing to prompt the participant to perform a task. Companion care is provided in accordance with a goal in the service plan.

Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under the Rehabilitation Act of 1973 or P.L. 94-142.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

To avoid duplication of services, including personal care, the support coordinator reviews the individual service plan to ensure the services reflect the goals described in the plan. Additionally, if the waiver participant's service plan list companion care services that appear to be another waiver service, for example personal care, the companion care waiver service will be reviewed closely. If the services being delivered are not companion care services the state will contact the support coordinator to explain the need to change the waiver service. The support coordinator will be responsible to contact the family to discuss and upon agreement the waiver participant's service plan will be updated to reflect the correct waiver service.

**Service Delivery Method (check each that applies):**

**Participant-directed as specified in Appendix E**

**Provider managed**

**Specify whether the service may be provided by (check each that applies):**

**Legally Responsible Person**

**Relative**

**Legal Guardian****Provider Specifications:**

Provider Category	Provider Type Title
Agency	Provider of Companion Care
Agency	Community Support Provider

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Companion Care****Provider Category:**

Agency

**Provider Type:**

Provider of Companion Care

**Provider Qualifications****License** (*specify*):

Childcare Home- Licensed by Department of Social Services pursuant to ARSD 67:42:04  
 Childcare Center-Licensed by Department of Social Services pursuant to ARSD 67:42:10  
 Before and After School Care Center-Licensed by Department of Social Services pursuant to 67:42:14

**Certificate** (*specify*):

Not applicable.

**Other Standard** (*specify*):

Adult Day Services Agency-Designated by Division of Developmental Disabilities as a qualified provider of Companion Care.  
University Center of Excellence in Developmental Disabilities (UCEDD)-Designated by Administration on Developmental Disabilities

The qualified Companion Care provider must meet the following criteria:

1. Have a signed provider agreement with the Division of Developmental Disabilities
2. Have a signed provider agreement with the Department of Social Services
3. Agency employees must meet the following qualifications:
  - a. Be at least 18 years of age unless there is an occasion when an agency employee at least 18 years is not available. On those occasions, the agency employee must be at least 16 years old.
  - b. Pass a criminal background check;
  - c. Be able to follow written or verbal instructions provided by the participant, guardian, advocate, or family member of the participant;
  - d. Have the abilities or skills necessary as determined by the participant to meet the participant's needs as outlined in the ISP; and
4. Have policies in the following areas:
  - a. Confidentiality
  - b. Drug-free workplace
  - c. Grievance
  - d. Emergency procedures and back-up plan
  - e. Sexual harassment
  - f. Abuse, neglect, exploitation
  - g. Safety
  - h. Universal precautions
  - i. Termination and notice requirements
  - j. Payment and billing

Oversight of the agency employee will be provided by the participant or legal guardian, advocate or family member of the participant. The provider will receive training as indicated in the service plan which is commensurate with the service or support to be provided, from the participant or legal guardian, advocate or family member of the participant in all companion care services delineated in the service plan. The companion care agency employee must be able to report changes in the participant's condition or needs to the legal guardian, advocate, or family member of the participant, maintain confidentiality and complete required record keeping.

#### **Verification of Provider Qualifications**

##### **Entity Responsible for Verification:**

Childcare Home-Department of Social Services  
Childcare Center-Department of Social Services  
Before and After School Care Center-Department of Social Services  
Adult Day Services Agency- Division of Developmental Disabilities  
UCEDD- Administration on Developmental Disabilities

##### **Frequency of Verification:**

Childcare Home-Annually  
Childcare Center-Annually  
Before and After School Care Center-Annually  
Adult Day Services Agency- Annually  
UCEDD- Every five years

## **Appendix C: Participant Services**

### **C-1/C-3: Provider Specifications for Service**

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**Service Type: Other Service****Service Name: Companion Care**

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**Provider Category:**

Agency

**Provider Type:**

Community Support Provider

**Provider Qualifications****License** (*specify*):

Not applicable.

**Certificate** (*specify*):

A CSP must be certified by the Division pursuant to Administrative Rules of South Dakota (ARSD) 46:11:02. The CSP must be an enrolled medicaid provider and have a provider agreement with DDD.

**Other Standard** (*specify*):

The companion care agency employee must be at least 18 years of age unless there is an occasion when a qualified employee at least 18 years is not available. On those occasions, the agency employee must be at least 16 years old.

Oversight of the agency employee will be provided by the participant or legal guardian, advocate or family member of the participant. The companion care agency employee must: be of good health, and able to read, write and follow instructions; be able to report changes in the participant's condition or needs to the legal guardian, advocate, or family member of the participant; maintain confidentiality and complete required record keeping; and have the ability or skills necessary to meet the participants needs as delineated in the service plan.

The AWC model does require agency employees to undergo a background check and the needed training for the service provided. The participant or the managing employer trains the agency employee on specific needs and services that the participant will require.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

DDD verifies qualified provider status on a biennial basis. Qualified providers have the responsibility of verifying companion care agency employee's age at time of hire. Support coordinators and families/participants have the responsibility of monitoring the service plan to ensure the provision of training and skills of the companion care agency employee.

**Frequency of Verification:**

see "entity responsible for verification."

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**Appendix C: Participant Services**

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**C-1/C-3: Service Specification**

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State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Environmental accessibility adaptations, (a.k.a., EAA)

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

Environmental accessibility adaptations include those physical adaptations to the home, required by the participants service plan, which are necessary to ensure the health, welfare, and safety of the participant, or which enable the participant to function with greater independence in the home, and without which, the participant would require institutionalization. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the participant. All services are provided in accordance with the applicable State and local building codes.

Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services are provided in accordance with applicable State and local building codes.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Home accessibility adaptations (a.k.a., environmental accessibility adaptations) to the waiver participants home are functionally assessed by the family/participant, support coordinator, and the State operating agency through standard procedures and policy. The adaptations must be required in the participants service plan, and are necessary to ensure health, welfare and safety of the participants or enable the participant greater independence. System implementation will include:

1. The family/participant, support coordinator and State operating agency will functionally assess the need of the adaptation.
2. When a request is over \$1,000, the support coordinator will:
  - a. Determine how long the family intends to stay in the current home;
  - b. If less than two years, the request will be submitted for justification via a prior authorization process;
  - c. If an unusual event or emergency occurs further review will be made by state operating agency to justify the purchase.

**Service Delivery Method** (*check each that applies*):

**Participant-directed as specified in Appendix E**

**Provider managed**

**Specify whether the service may be provided by** (*check each that applies*):

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Community Support Provider

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**

**Service Name: Environmental accessibility adaptations, (a.k.a., EAA)**

**Provider Category:**

Agency

**Provider Type:**

Community Support Provider

**Provider Qualifications**

**License** (*specify*):

Not applicable.

**Certificate** (*specify*):

A CSP must be certified by the Division pursuant to Administrative Rules of South Dakota (ARSD) 46:11:02. The CSP must be an enrolled medicaid provider and have a provider agreement with DDD.

**Other Standard** (*specify*):

Qualified providers will make arrangements with a supplier/vendor. Vendor for the purpose of this application means the supplier of a product or service to be purchased by an approved agency for a recipient of services under this waiver. In order to be approved as a vendor the product or service to be delivered must meet all applicable manufacturers specifications. Provider must meet applicable Uniform Building Code and Specifications set forth by the ADA Accessibility Guidelines.

### Verification of Provider Qualifications

#### Entity Responsible for Verification:

DDD verifies qualified provider status on a biennial basis. Qualified providers have the responsibility of coordinating with the vendor/supplier. Support coordinators and/or families/participants provide oversight and monitoring of environmental adaptations.

#### Frequency of Verification:

See "entity responsible for verification".

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

#### Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

#### Service Title:

Nutritional Supplements

#### HCBS Taxonomy:

##### Category 1:

##### Sub-Category 1:

##### Category 2:

##### Sub-Category 2:

##### Category 3:

##### Sub-Category 3:

##### Category 4:

##### Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

**Service is not included in the approved waiver.**

**Service Definition** (*Scope*):

Nutritional Supplements; also includes nutritional supplements when they are not available under the EPSDT benefits or the Medicaid State Plan and prescribed by a doctor.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

**Service Delivery Method** (*check each that applies*):

**Participant-directed as specified in Appendix E**

**Provider managed**

**Specify whether the service may be provided by** (*check each that applies*):

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Community Support Provider

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**

**Service Name: Nutritional Supplements**

**Provider Category:**

Agency

**Provider Type:**

Community Support Provider

**Provider Qualifications**

**License** (*specify*):

Not applicable.

**Certificate** (*specify*):

A CSP must be certified by the Division pursuant to Administrative Rules of South Dakota (ARSD) 46:11:02. The CSP must be an enrolled medicaid provider and have a provider agreement with DDD.

**Other Standard** (*specify*):

Qualified providers will make arrangements with a supplier/vendor. Vendor, for the purpose of this application, means the supplier of a product or service to be purchased by an approved agency for a recipient of services under this waiver. In order to be approved as a vendor the product or service to be delivered must meet all applicable manufacturers specifications.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Division of Developmental Disabilities verifies qualified provider status on a biennial basis. Qualified providers have the responsibility of coordinating with the vendor/supplier. Support coordinators and/or families/participants provide oversight and monitoring of nutritional supplements.

**Frequency of Verification:**

See "Entity Responsible for Verification."

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Specialized Medical Adaptive Equipment and Supplies (a.k.a., SMAES)

**HCBS Taxonomy:****Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**


Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

Specialized medical and adaptive equipment and supplies include devices, controls, or appliances, specified in the service plan, which enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

This service includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan or through EPSDT for participants under age 21. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation. Examples include, but are not limited to, modified bikes, adaptive clothing, adaptive clothing, eating and cooking utensils, picture cookbooks, and medication minders. To ensure the services remains flexible to meet the needs of waiver participant this is not an all-encompassing list.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

**Service Delivery Method** (*check each that applies*):

**Participant-directed as specified in Appendix E**

**Provider managed**

**Specify whether the service may be provided by** (*check each that applies*):

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Community Support Provider

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**

**Service Name: Specialized Medical Adaptive Equipment and Supplies (a.k.a., SMAES)**

**Provider Category:**

Agency

**Provider Type:**

Community Support Provider

**Provider Qualifications**

**License** (*specify*):

Not applicable.

**Certificate** (*specify*):

A CSP must be certified by the Division pursuant to Administrative Rules of South Dakota (ARSD) 46:11:02. The CSP must be an enrolled medicaid provider and have a provider agreement with DDD.

**Other Standard** (*specify*):

"Vendor" in this application means the supplier of a product or service to be purchased by an approved agency or individual provider for a recipient of services under this waiver. In order to be approved as a vendor the product or service to be delivered must meet all applicable manufacturers specifications.

#### Verification of Provider Qualifications

##### Entity Responsible for Verification:

DDD verifies qualified provider status on a biennial basis. Qualified providers have the responsibility of coordinating with the vendor/supplier. Support coordinators and/or families/participants provide oversight and monitoring of SMAES.

##### Frequency of Verification:

See "entity responsible for verification."

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

#### Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

#### Service Title:

Specialized Therapies

#### HCBS Taxonomy:

##### Category 1:

11 Other Health and Therapeutic Services

##### Sub-Category 1:

11130 other therapies

##### Category 2:

##### Sub-Category 2:

##### Category 3:

##### Sub-Category 3:

##### Category 4:

##### Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

**Service Definition (Scope):**

Art therapy is used to:

- Increase awareness of self and others,
- Cope with symptoms, stress and traumatic experiences, and
- Enhance cognitive abilities

Music therapy is used to help recipients improve their cognitive functioning, motor skills, emotional and affective development, behavior and social skills and their quality of life. Music therapy may be provided individually or with others in groups.

Hippotherapy/therapeutic horseback riding is used to promote the use of the movement of the horse as a treatment strategy in physical, occupational and speech-language therapy sessions for people living with disabilities. The movement of the horse provides physical and sensory input which is variable, rhythmic and repetitive. Equine movement coerces the recipient to use muscles and body systems in response to movement of the horse.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Therapy services are limited to \$1500 annually

**Service Delivery Method (check each that applies):**

**Participant-directed as specified in Appendix E**

**Provider managed**

**Specify whether the service may be provided by (check each that applies):**

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Therapist

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**

**Service Type: Other Service**

**Service Name: Specialized Therapies**

**Provider Category:**

Individual

**Provider Type:**

Therapist

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard** (*specify*):
**Verification of Provider Qualifications****Entity Responsible for Verification:**

**Frequency of Verification:**


## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**


As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

**HCBS Taxonomy:****Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**


Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

Vehicle Modification consists of adaptations or alterations to an automobile or van that is the waiver participants primary means of transportation in order to accommodate the special needs of the participant. Vehicle adaptations are specified by the service plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. The following are specifically excluded:

1. Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the participant;
2. Purchase or lease of a vehicle and;
3. Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of modifications.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

**Service Delivery Method (check each that applies):**

**Participant-directed as specified in Appendix E**

**Provider managed**

**Specify whether the service may be provided by (check each that applies):**

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Community Support Provider

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**

**Service Name: Vehicle Modification**

**Provider Category:**

Agency

**Provider Type:**

Community Support Provider

**Provider Qualifications**

**License (specify):**

Not applicable.

**Certificate (specify):**

A CSP must be certified by the Division pursuant to Administrative Rules of South Dakota (ARSD) 46:11:02. The CSP must be an enrolled medicaid provider and have a provider agreement with DDD.

**Other Standard (specify):**

"Vendor" in this application means the supplier of a product or service to be purchased by an approved agency or individual provider for a recipient of services under this waiver. In order to be approved as a vendor the product or service to be delivered must meet all applicable manufacturers specifications.

Providers of vehicle adaptations shall have a current license, certification, or registration with the State of South Dakota as appropriate for the services being purchased. The provider shall also possess a current license to do business issued in accordance with the laws of the local jurisdiction within which the individual or agency is located.

Providers shall demonstrate knowledge in meeting applicable standards of installation, repair, and maintenance of vehicle adaptations and shall also be authorized by the manufacturer to install, repair, and maintain such systems where possible.

#### **Verification of Provider Qualifications**

##### **Entity Responsible for Verification:**

DDD verifies qualified provider status on a biennial basis. Qualified providers have the responsibility of coordinating with the vendor/supplier. Support coordinators and/or families/participants provide oversight and monitoring vehicle modifications.

##### **Frequency of Verification:**

See "Entity Responsible for Verification."

## **Appendix C: Participant Services**

### **C-1: Summary of Services Covered (2 of 2)**

**b. Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

**Not applicable** - Case management is not furnished as a distinct activity to waiver participants.

**Applicable** - Case management is furnished as a distinct activity to waiver participants.

*Check each that applies:*

**As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*

**As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*

**As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*

**As an administrative activity.** *Complete item C-1-c.*

**As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

**c. Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

## **Appendix C: Participant Services**

### **C-2: General Service Specifications (1 of 3)**

**a. Criminal History and/or Background Investigations.** Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

**No. Criminal history and/or background investigations are not required.**

**Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Each provider must conduct a criminal background check for each new part-time and full-time employee prior to hiring. DHS/DDD recommends the utilization of the county clerk of courts system as it appears to be cost effective and time efficient. The DHS/DDD reviews a sample of Agency with Choice employees, utilizing a 95% confidence level and a 5% confidence interval with a response distribution of 50%, to ensure that criminal background checks have been completed.

Providers that meet the requirements of SDCL 13-10-12 are exempt from this requirement. SDCL 13-10-12 addresses criminal background investigations of teachers and employees hired by school districts. Providers are required to apply the exclusions as outlined in the Social Security Act 1128, which addresses mandatory and permissive exclusions from programs receiving federal funding and includes the employment of a staff member who meets the exclusionary criteria.

Additionally, all employees are screened against the OIG exclusionary list as required by State Medicaid Director Letter #09-001.

**b. Abuse Registry Screening.** Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

**No. The state does not conduct abuse registry screening.**

**Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

## Appendix C: Participant Services

### C-2: General Service Specifications (2 of 3)

**c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:***

**No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

**Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

## Appendix C: Participant Services

**d. Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

**No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**

**Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of **extraordinary care** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

**Self-directed**

**Agency-operated**

**e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

**The state does not make payment to relatives/legal guardians for furnishing waiver services.**

**The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

**Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

**Other policy.**

Specify:

The State does not pay legally responsible individuals for providing waiver services. A legally responsible individual includes the parent of a minor child (under age 18) or the spouse of a participant.

The State does pay the parent or legal guardian of an adult participant (age 18 and older) for providing Personal Care 1, Respite Care, Supported Employment and Companion Care. The provider must meet all service specifications outlined in C-3 as well be an employee under the Agency with Choice model. Services must also be rendered as specified in the participant's service plan.

The support coordinator is responsible for the monitoring and oversight of the service plan. The support coordinator ensures that the service plan addresses the participant's desired outcomes, needs and preferences. Service plans are reviewed at least quarterly and revised at least annually. A waiver participant/family may contact their support coordinator at any time to request/receive a change in planned services.

Provider rates and units of services are prescribed in the internet based service plan. Providers may view and submit time cards specific to their services. Participants and support coordinators authorize these services to be paid.

**f. Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Pursuant to ARSD 67:54:04:19, to participate in the delivery of HCBS, providers shall be approved by DHS according to ARSD Chapter 46:11. Providers shall have a signed provider agreement with DHS and DSS. These agreements must be renewed annually.

Pursuant to ARSD 67:16:33:02, to receive reimbursement for covered medical services which are medically necessary and which are provided to eligible recipients, a provider must have a provider agreement with DSS. The agreement must be signed by the individual who is requesting to become a participating provider or by an agent of the facility or corporation that is requesting to become a participating provider and approved and signed by DSS. Only those individuals or facilities which meet licensure and certification requirements listed in this article may be participating providers.

A qualified provider of Family Support 360 waiver services is defined in SDCL 27B-1-17(3) Community Services Provider (SP) and 27B-1-17(4) Community Supports Provider (CSP). CSPs must be nonprofit corporations incorporated according to SDCL chapters 47-22 to 47-28, inclusive. CSPs must meet the definition for tax exemption status according to § 501(c)(3) of Title 26 of the Internal Revenue Code, October 22, 1986, as in effect on December 20, 1995. SPs may be non-profit or for-profit organizations. The requirements for certification of CSPs and SPs are contained in ARSD Article 46:11. The requirements of certification of a CSP are contained in ARSD chapter 46:11. These requirements include:

- 1) The organization has filed articles of incorporation and nonprofit status with the secretary of state and has bylaws which are approved by its board of directors;
- 2) The agency must meet certification requirements in ARSD 46:11:02 to 46:11:05 inclusive; assure the health and safety of the participants receiving services under chapter 46:11:06; meet the requirements of ARSD Chapter 46:11 and demonstrate compliance with a life quality review to assess personal outcomes in the areas of choice, relationships, lifestyle, health and well-being, rights, and satisfaction; and
- 3) The organization may provide services to participants when provisional certification is received. The provisional certificate is effective for no more than six months. DHS/DDD shall survey the organization six months of provisional certification.

ARSD 46:11:02 to 46:11:05 contain standards in the area of:

- 1) CSP policy on abuse, neglect, and exploitation;
- 2) Incident reporting;
- 3) Termination of services;
- 4) Notice requirements;
- 5) Appeals;
- 6) Grievances;
- 7) Rights restrictions;
- 8) Due process;
- 9) Accounting practices;
- 10) Cost reports;
- 11) Annual audits;
- 12) Retention/protection of records;
- 13) Insurance;
- 14) Management of personal finances;
- 15) Administrative office hours;
- 16) Confidentiality of information;
- 17) Service team;
- 18) Assessments;
- 19) Plan of care;
- 20) Restrictive procedures;
- 21) Service coordinator responsibilities;
- 22) Training;
- 23) On-call staff;
- 24) Safety and sanitation; and
- 25) Life safety codes

Qualifications for support coordinators are standardized throughout CSPs with minimum qualifications specified in Appendix C-1. Participants are free to choose a support coordinator from any CSP. Families/participants are provided with materials to make an informed decision.

Other agencies that provide Personal Care 1, respite, companion care and supported employment are designated by the Division of Developmental Disabilities as qualified providers if they meet the following criteria:

1. Have a signed Medicaid provider agreement with the Department of Social Services
  2. Obtain a signed provider agreement with the Division of Developmental Disabilities by meeting the following qualifications:
    - a. All employees must meet the age requirements for each service specified;
    - b. All employees must pass a criminal background check;
    - c. All employees must be able to follow written or verbal instructions provided by the participant, guardian, advocate, or family member of the participant; and
    - d. All employees must have the abilities or skills necessary as determined by the participant to meet the participant's needs as outlined in the ISP.
    - e. Have policies in the following areas:
      - Confidentiality
      - Drug-free workplace
      - Grievance
      - Emergency procedures and back-up plan
      - Sexual harassment
      - Abuse, neglect, exploitation
      - Safety
      - Universal precautions
      - Termination and notice requirements
      - Payment and billing
- DHS/DDD has kept provider qualifications sufficiently broad to attract qualified personnel, provide participants free choice of qualified providers and ensure sustainable services.
- Agencies seeking to become qualified providers of waiver services may contact the Division of Developmental Disabilities to inquire about provider enrollment and receive instructions regarding the enrollment process. Additionally, the information governing provider enrollment is readily available on the DHS/DDD website.

## Appendix C: Participant Services

### Quality Improvement: Qualified Providers

*As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.*

#### **a. Methods for Discovery: Qualified Providers**

*The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.*

##### **i. Sub-Assurances:**

- a. Sub-Assurance:** *The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

##### **Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

##### **Performance Measure:**

**Percentage of providers which continue to be in compliance with state and federal requirements. Numerator - Number of existing providers which continue to meet certification standards/Denominator - Number of total existing providers reviewed.**

**Data Source** (Select one):**Provider performance monitoring**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<b>Other</b> Specify: <div style="border: 1px solid black; padding: 5px;">             All providers will be reviewed in a two year period, 1/2 in one year and 1/2 the next year.           </div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

**Performance Measure:**

**Percentage of new providers in compliance with state and federal requirements prior to delivery of services. Numerator - Number of new providers who meet initial certification standards prior to the delivery services. Denominator - Total number of new providers.**

**Data Source** (Select one):

**Provider performance monitoring**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
<b>Other</b> Specify:	<b>Annually</b>	<b>Stratified</b> Describe Group:

<input type="text"/>		<input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**b. Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.**

*For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**c. Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.**

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

**Percentage of newly hired support coordinators in compliance with training requirements. Numerator - Number of newly hired support coordinators who received training/ Denominator - total number of newly hired support coordinators.**

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify:	

	All providers will be reviewed in a two year period, 1/2 in one year and 1/2 the next year.	
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**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div></div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div></div>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Biennial Surveys of Qualified Providers: Utilizing a comprehensive survey tool, the DHS/DDD surveys a statistically valid sample of participants to include a review of participant files, employee personnel records, and claims. The waiver administrator is responsible for aggregating quarterly and annual information for analysis by the Internal Waiver Review Committee (IWRC). This information is also provided to the Family Support Council as requested. Their findings and recommendations are reported to the DHS/DDD Director and the SSMA for remediation.

The State does not have non-licensed/non-certified providers as a result there will not be any identified performance measures for B sub-assurance.

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The primary discovery activities that have the potential to reveal individual problems related to the provision of services by qualified providers include complaint referrals to DHS/DDD, Biennial provider surveys, including Claims Review, National Core Indicator surveys, requests for administrative hearings, grievances, and public forums.

When an individual problem is discovered, DHS/DDD takes immediate action to assess, and if necessary, ensure the safety of the individual and other waiver participants. As merited by the situation, DHS/DDD may request additional information from the provider and/or conduct an onsite investigation. As appropriate, DHS/DDD may make a referral to Child Protective Services, Long Term Services and Supports, Law Enforcement, and/or the Medicaid Fraud Control Unit. Issues that pose a serious threat to health or safety or demonstrate continued failure to meet state requirements can result in provider sanctions to include a plan of correction, probationary status and decertification.

The problem would be individually documented and systemically remediated through the discovery activity that revealed the problem. Additional information may be documented in the individual's file maintained by DHS/DDD.

A1) Prior to delivering services, a provider is required to meet ARSD and Waiver assurances. Any deficiencies will be recorded by the DHS/DDD and the provider will be required to address prior to the delivery of any services. The DDD will continue to provide technical assistance during this process to ensure all requirements are met prior to certification.

A2) If a provider is determined to not meet certification standards the provider would be subject to sanctions which may include probationary status to decertification. If a provider is placed on probationary status they are not allowed to enroll any new waiver participants. If a provider is decertified the DHS/DDD will assist waiver participants with transition to a new provider.

## ii. Remediation Data Aggregation

### Remediation-related Data Aggregation and Analysis (including trend identification)

<b>Responsible Party</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div></div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div></div>

## c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix C: Participant Services

### C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

## Appendix C: Participant Services

### C-4: Additional Limits on Amount of Waiver Services

**a. Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

**Not applicable-** The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

**Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

**Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.  
*Furnish the information specified above.*

**Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.  
*Furnish the information specified above.*

**Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.  
*Furnish the information specified above.*

**Other Type of Limit.** The state employs another type of limit.  
*Describe the limit and furnish the information specified above.*

## Appendix C: Participant Services

### C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

*Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.*

Please see attachment #2 for information.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (1 of 8)

#### State Participant-Centered Service Plan Title:

Individualized Service Plan (ISP)

- a. Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

**Registered nurse, licensed to practice in the state**

**Licensed practical or vocational nurse, acting within the scope of practice under state law**

**Licensed physician (M.D. or D.O)**

**Case Manager** (qualifications specified in Appendix C-1/C-3)

**Case Manager** (qualifications not specified in Appendix C-1/C-3).

*Specify qualifications:*

**Social Worker**

*Specify qualifications:*

**Other**

*Specify the individuals and their qualifications:*

**Appendix D: Participant-Centered Planning and Service Delivery**

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**D-1: Service Plan Development (2 of 8)****b. Service Plan Development Safeguards.** *Select one:*

**Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

**Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

**Appendix D: Participant-Centered Planning and Service Delivery**

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**D-1: Service Plan Development (3 of 8)**

- c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The Family Support 360 Waiver program empowers participants and families to exercise choice and control over their services and supports within the outlines program guidelines. Prior to the service plan meeting the support coordinator consults the participant and his/her legal guardian and/or the participant's advocate if there is one. The purpose is to discuss the services, participant's preferences, goals, and desires for the next year and determine who the family/participant would like to include in the planning process. This occurs as follows:

The coordinator shall:

- (a) Identify the ISP team within 15 calendar days of service being initiated;
- (b) Complete the ISP within 30 calendar days of service being initiated; and
- (c) Implement the ISP within 45 calendar days of service being initiated.

The ISP must be developed with the participant, the participant's parent if the participant is under 18 years of age, or the participant's guardian, if any. The coordinator shall review the ISP quarterly with the participant, the participant's parent if the participant is under 18 years of age, or the participant's guardian, if any, and document the outcome of the review and any recommendations regarding the status of the ISP.

The support coordinator meets with the family/participant in person to discuss current services, needs and the participant's life in general. This discussion would include concerns that the family/participant is currently experiencing. From that conversation the support coordinator compiles a list of items for discussion during service plan development. The family/participant is asked to consider who to include and to what extent each person should be included. The support coordinator will then make arrangements for everyone identified to meet. All children are encouraged to participate in the planning process. Children reluctant to participate are encouraged to participate at least for a few minutes. The ISP must include the participant's vision of a good life, including: People, places, experiences, and possessions, which bring satisfaction, joy, and contentment to the participant; and supports that promote the participant's health, safety, and role as a valued member of the community. Information is gathered through the person-centered discovery process.

Prior to and during the meeting the support coordinator reviews a list of Family Support and other services available through the review of the program fiscal guidelines with the family/participant. The service plan is then developed with the team on a "hard copy", adding things as deemed appropriate by the group through discussion. The support coordinator then creates an electronic version or final draft of the plan which is then shared with the family/participant to correct/amend/approve as they deem appropriate.

If additional people to include are identified during the face-to-face meeting, additional meetings will be held to get their input.

Families/participants are reminded throughout this process of the ability to change the service plan as the participant's need for services changes. Service plans must be updated at least annually but as often as necessary to support the changing needs of the participant.

Person-centered planning is used in all phases of the service plan development process.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (4 of 8)

- d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and

policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a) The support coordinator develops the service plan under the direction of the family/participant and people designated by the family/participant as team planning members. All services authorized in the service plan must be in compliance with program guidelines. The support coordinator, the family and/or participant, and whoever else may be designated by the family and/or participant participate in the process.

For new applicants, the purpose is to discuss the services, participant's preferences, goals, and desires for the next year and determine who the family/participant would like to include in the planning process. This occurs as follows:

The coordinator shall:

- (a) Identify the ISP team within 15 calendar days of service being initiated;
- (b) Complete the ISP within 30 calendar days of service being initiated; and
- (c) Implement the ISP within 45 calendar days of service being initiated.

For participants, service plans are reviewed at least quarterly and revised at least annually. A family/participant may contact a support coordinator at any time to request/receive a change in planned services to address changes in the participant's needs.

(b) During the initial face-to-face meeting the support coordinator completes an Inventory of Client and Agency Planning (ICAP) as part of the level of care requirements for waiver eligibility. The ICAP is also utilized to assess service needs. The support coordinator also makes arrangements to receive a psychological report and any other medical/behavioral/therapy-related reports. The support coordinator uses person-centered planning to identify the family/participant's preferences and goals. An "initial assessment" form is completed with all new families/participants, prior to the service plan being developed, that synthesizes all of the information gathered through the assessment process that covers the following areas:

1. General family/participant information;
2. Medical information;
3. Areas for discussion, to include feeding, dressing, toileting, mobility, learning, vision, hearing, receptive and expressive language, danger awareness, social/emotional, and other areas specified by the family/participant;
4. Current supports; and
5. Additional supports

The ISP must include the participant's vision of a good life, including: People, places, experiences, and possessions, which bring satisfaction, joy, and contentment to the participant; and supports that promote the participant's health, safety, and role as a valued member of the community. Information is gathered through the person-centered discovery process. This provides one more avenue for the support coordinator to ensure all preferences and needs have been identified and addressed on the service plan.

(c) The support coordinator shares a family support brochure and website information, a list of available waiver services through a review of the program guidelines and other community services, supports and resources with each participant. The support coordinator is also knowledgeable of other resources and shares that information during the planning process.

The support coordinator ensures that the service plan addresses the participant's desired outcomes, needs and preferences. This is done during quarterly contacts/reviews and/or a service plan meeting.

The family/participant designates responsibility for implementing the service plan, and collaborates with the support coordinator to coordinate waiver and other State Plan services. The support coordinator is not responsible for the health care needs of the participant. The support coordinator as directed by the participant/family provides assistance to coordinate and/or secure services necessary for this area.

The support coordinator is responsible for the monitoring and oversight of the service plan. At the request of a legally responsible guardian and/or participant designee, this responsibility may be shared with an appropriately designated

person.

The DHS/DDD provides oversight regarding the ISP development process, implementation and monitoring through the representative random sample review of participant records. In the event an issue is identified, the qualified provider is required to respond to the problem within 10 days of discover. The DHS/DDD monitors the remediation efforts until the issue is fixed.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (5 of 8)

- e. Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

During the service plan development process community resources are shared with the participant and family. This should include information on public assistance for families with home heating and cooling issues, and possible referrals to food stamp or other income-based programs. It should also include information on stranger danger, pedestrian and bicycle safety, fire and home safety, disaster preparedness, safety checklist and vehicle safety. In addition, information is provided on child development, immunizations and prevention services. This information is discussed in detail and a plan is formulated for those instances where risk might be a possibility.

Any critical services upon which the participant depends for health, welfare and safety are accompanied by a back up plan for provision of services when the service provider is unavailable. If the need for a back up plan is identified this is included within the ISP. The support coordinator provides emergency contact information as well as a business card for posting in the family home.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (6 of 8)

- f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

At least annually, each participant is informed of and acknowledges the right to freedom of choice in providers. Initially and during annual service plan reviews, families and participants are given a list of qualified providers of waiver services. The list of support coordinators includes a one-page profile of each support coordinator and describes their areas of expertise in providing service coordination and services to participants and families. Information regarding qualified providers is available from the support coordinator anytime during the year and is also available on the internet.

DHS/DDD supports an Agency With Choice participant-directed service model in which participants are able to recruit, hire and manage in-home care providers, including Personal Care 1, Companion Care, Respite Care and Supported Employment providers. Participants serve as managing co-employers of these providers.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (7 of 8)

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

DSS exercises administrative authority, supervision, and oversight of the waiver and issues policies, rules and regulations related to the waiver. The existing MOU between DHS and DSS indicates the responsibility of DSS to review waiver participant's plans to ensure that waiver requirements are met. A copy of the MOU setting forth the authority and arrangements for this policy is on file with DHS and DSS.

The DHS/DDD implemented the SMART system, an online review system, in 2011 to compile and calculate performance measures for the Family Support 360 waiver. At the time of development and implementation the DHS/DDD utilized a response distribution rate of 50% to ensure an appropriate sample size was achieved as the review tool and methodologies had changed. This initial year of a response distribution rate provided the DHS/DDD with the historical data needed to move forward with determination of distribution rates in subsequent years. Each year the DHS/DDD utilizes the previous waiver year's review results to determine the appropriate distribution rate for the following waiver year. This process is fluid and has allows the DHS/DDD to adjust the distribution rate according to the wealth of data contained within the online review system. The SMART system allows the DDD to facilitate review of compliance with SSMA oversight of the performance of waiver functions. The SMART system aligns existing quality assurance and improvement processes with federal reporting requirements while concurrently producing meaningful information for systemic improvements.

DHS/DDD conducts a biennial ARSD/HCBS review which includes a representative, random sample of service plans. With the implementation of the SMART system a sample size calculator is utilized to determine a representative random sample of participant plans to be reviewed during each waiver year. One-twelfth of the total number of participant files, necessary to meet the sample size, are reviewed each month. This process begins in June and ends the following May. Upon completion of this review cycle these results are utilized to determine a representative random sample for the next year. This process continues and a new representative random sample is determined each waiver year based on the previous years review cycle results. Each year the sample size will be figured using a sample size calculator that takes into account the margin of error, the confidence level, the population size and the response distribution of the previous years review cycle results.

For the purposes of calculating a statistically valid sample size, a 5% margin of error, a 95% confidence level, and the most recent population size will be used. A review of the most recent review cycle results will provide the response distribution percentage.

The inspection of care findings include appropriateness of services, quarterly reviews of plans for possible changes in plans of care, specific services being provided, fiscal review of services rendered, documentation of service coordination, and review of possible abuse and neglect situations. This sample, along with DDD recommendations are referred to DSS for monitoring, oversight, and final approval. The SSMA and SMD have real time access to the SMART review system. This allows the SSMA and SMD the ability to review individual file findings, provider agency findings, systemic reports, and operating agency reports.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (8 of 8)

- h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

**Every three months or more frequently when necessary**

**Every six months or more frequently when necessary**

**Every twelve months or more frequently when necessary**

**Other schedule**

*Specify the other schedule:*

- i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

**Medicaid agency**

**Operating agency**

**Case manager**

**Other**

*Specify:*

## Appendix D: Participant-Centered Planning and Service Delivery

### D-2: Service Plan Implementation and Monitoring

- a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

DDD conducts a biennial ARSD/HCBS review which includes a representative, random sample of service plans. The statistically valid sample size is based upon historical data from previous review cycle. The sample size is derived by using a sample size calculator that takes into account the margin of error, the confidence level, the population size and the response distribution of previous review cycle results.

For the purposes of calculating a statistically valid sample size, a 5% margin of error, a 95% confidence level, and the most recent population size will be used. A review of the most recent review cycle results will provide the response distribution percentage.

The inspection of care findings include appropriateness of services, quarterly reviews of plans for possible changes in plans of care, specific services being provided, fiscal review of services rendered, documentation of service coordination, and review of possible abuse and neglect situations. This sample, along with DDD recommendations are referred to DSS for monitoring, oversight, and final approval. The SSMA and SMD have real time access to the SMART review system. This allows the SSMA and SMD the ability to review individual file findings, provider agency findings, systemic reports, and operating agency reports.

The support coordinator conducts annual Individual Service Plan reviews and quarterly monitoring reviews with each participant they work with. A participant/family may contact their support coordinator at any time to for assistance to address needed changes. The support coordinator is also responsible for identifying issues/concerns with waiver or other services and supporting the participant/family in taking appropriate corrective action steps. If at any time a support coordinator believes a participant is at risk of harm, the support coordinator must arrange and conduct a safety check that includes a face-to-face meeting. When appropriate, the support coordinator must take immediate steps necessary to protect the participant. The support coordinator, as required by the DHS/DDD critical incident reporting guidelines, must report to the DHS/DDD. The support coordinator and the DHS/DDD must follow the critical incident reporting guidelines described in Appendix G.

- b. Monitoring Safeguards.** *Select one:*

**Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**

**Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

## Appendix D: Participant-Centered Planning and Service Delivery

### Quality Improvement: Service Plan

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

#### a. Methods for Discovery: Service Plan Assurance/Sub-assurances

*The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.*

##### i. Sub-Assurances:

- a. *Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.*

##### Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

##### Performance Measure:

**Percentage of participant Individual Service Plans (ISP) that address participant needs. Numerator - Number of participant's ISPs which address the participant's identified needs/Denominator - Total number of participant ISPs reviewed.**

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =

		95% confidence level; Confidence interval of 5.
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Percentage of participant Individual Service Plans (ISP) that address participant**

**health and safety risk factors identified in the safety checklist. Numerator - Number of participant ISPs which address participant health and safety factors identified in the safety checklist/Denominator - Number of ISPs reviewed.**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;">             95% confidence level;              Confidence interval of 5.           </div>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 250px; margin-top: 5px;"></div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 250px; margin-top: 5px;"></div>

**Performance Measure:**

**Percentage of participant's Individual Service Plans (ISP) that address personal goals; Numerator - Total number of participant ISPs that address personal goals/ Denominator - Total number of participant ISPs reviewed.**

**Data Source** (Select one):**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> 95% Confidence level;  Confidence interval of 5 </div>

<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/>

- b. Sub-assurance:** *The State monitors service plan development in accordance with its policies and procedures.*

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or*

*sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

- c. Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.**

#### **Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

#### **Performance Measure:**

**Percentage of participant ISPs that have been updated within 12 months of the most recent ISP; Numerator - Number of participant ISPs that have been updated within 12 months of the most recent ISP/ Denominator - total number of participant ISPs reviewed.**

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 5px; width: fit-content;">             95% Confidence level;              Confidence interval of 5           </div>
<b>Other</b> Specify:	<b>Annually</b>	<b>Stratified</b> Describe Group:

<input type="text"/>		<input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

Percentage of participant ISPs that have been updated when the needs of the participant have changed. Numerator - Number of participant's ISPs that were revised when the needs of the participant changed/Denominator - Total number of participant ISPs reviewed with an identified change in need.

**Data Source** (Select one):**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 5px; width: fit-content;">             95% confidence level;              Confidence interval of 5.           </div>
<b>Other</b> Specify:  <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<b>Other</b> Specify:  <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b>	<b>Annually</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

- d. *Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.*

#### Performance Measures

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

#### Performance Measure:

**Percentage of participant ISPs that are monitored quarterly to assure the participant receives the type, scope, amount, duration, and frequency of services as outlined in the ISP. Numerator - The number of participant ISPs that report that participants receive services in the type, scope, amount, duration, and frequency outlined in the ISP. Denominator-total number of participant ISPs reviewed.**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative</b>

		<b>Sample</b> Confidence Interval = <div>95% Confidence level; Confidence interval of 5</div>
<b>Other</b> Specify: <div></div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div></div>
	<b>Other</b> Specify: <div></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div></div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):

**e. Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.**

#### Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

#### Performance Measure:

**Percentage of participants given the choice between institutional care and community based services at the time of application for waiver services; Numerator - number of participants given the choice between institutional care and community based services at the time of application as documented on the LOC application/Denominator - total number of initial LOC applications reviewed.**

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div></div>
<b>Other</b> Specify:	<b>Annually</b>	<b>Stratified</b> Describe Group:

<input type="text"/>		<input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Percentage of participants provided the choice between qualified providers;**  
**Numerator - The number of participant records reviewed that reflect participants were provided choice of qualified providers / Denominator - total number of participant records reviewed.**

**Data Source** (Select one):**Record reviews, off-site**

If 'Other' is selected, specify:

**This data source captures data related to participant files reviewed to ensure annually the participant was provided the choice of qualified providers.**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 5px; width: fit-content;">             95% confidence level;              5% confidence interval           </div>
<b>Other</b> Specify:  <div style="border: 1px solid black; height: 30px; width: 150px;"></div>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <div style="border: 1px solid black; height: 30px; width: 120px;"></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <div style="border: 1px solid black; height: 30px; width: 120px;"></div>
	<b>Other</b> Specify:  <div style="border: 1px solid black; height: 30px; width: 150px;"></div>	

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

**This data source captures data related to initial waiver level of care applications to ensure the participant was provided with the choice of qualified providers.**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid</b>	<b>Weekly</b>	<b>100% Review</b>

<b>Agency</b>		
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
	Specify: <div></div>

**Performance Measure:**

**Percentage of participants provided the choice of waiver services. Numerator - The number of participant records reviewed that reflect participants were provided choice of waiver services/Denominator-total number of participant records reviewed.**

**Data Source** (Select one):**Operating agency performance monitoring**

If 'Other' is selected, specify:

**This data source captures data related to initial waiver level of care applications to ensure the participant was provided the choice of waiver services.**

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div></div>
<b>Other</b> Specify: <div></div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div></div>
	<b>Other</b> Specify:	

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**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

**This data source captures data related to participant files reviewed to ensure annually the participant was provided with choice of waiver services.**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <div>95% confidence level; 5% confidence interval</div>
<b>Other</b> Specify:  <div></div>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <div></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <div></div>
	<b>Other</b> Specify:  <div></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 240px; margin-top: 5px;"></div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 240px; margin-top: 5px;"></div>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The DHS/DDD implemented an online review system in 2011 to compile and calculate performance measures for the Family Support 360 waiver. At the time of development and implementation the DHS/DDD utilized a response distribution rate of 50% to ensure an appropriate sample size was achieved to set the required historical baseline as the review tool and methodologies had changed. After the initial year of baseline data the DHS/DDD utilizes the previous waiver year's review results to determine the appropriate distribution rate for the following waiver year. This process is fluid and has allowed the DHS/DDD to adjust the distribution rate according to the wealth of data contained within the online review system. The aforementioned system is known as the Systemic Monitoring and Reporting Technology (SMART) system. The SMART system allows the DDD to facilitate review of compliance with SSMA oversight of the performance of waiver functions. The SMART system aligns existing quality assurance and improvement processes with federal reporting requirements while concurrently producing meaningful information for systemic improvements.

The SMART system allows the DHS/DDD to review performance data related to waiver participant center planning and service delivery for individual remediation and systemic trends. The waiver manager is responsible for completing the aggregation and analysis of this information continuously and providing the analysis to the SSMA at least quarterly or more often as requested by the SSMA. The waiver administrator presents the quality data to the SSMA during Internal Waiver Review Committee meetings. The SSMA can review waiver performance and corresponding data within the SMART system at any time as they have direct access to the system. Each error identified within the SMART system is remediated at an individual level and the data monitored for systemic issues. Ultimately, at the time the data is shared with the SSMA the errors and/or systemic issues have been addressed. The SSMA provides additional direction as necessary to ensure compliance with the written waiver. In addition the data related to each of these performance measures is provided to the Family Support Council as requested.

The waiver administrator is responsible for aggregating quarterly and annual data for remediation by the SSMA and the IWRC. The SSMA, Family Support Council and the IWRC monitors performance measures related to the timeliness of initial LOC determinations and the accuracy of initial determinations. LOC determinations are made by DHS/DDD QIDP or a qualified DHS/DDD staff who may request clinical consultation on difficult determinations.

**Claims Review:** Qualified providers are required to participate in an annual billing review process conducted by a DHS management analyst, in which a review is conducted on a statistically valid sample of participants' claims to ensure and validate the accuracy of record keeping, supporting documentation, and the resulting claims submitted for payment. Findings are compiled, reviewed by the Family Support Waiver Administrator, and, if necessary, addressed in a plan of correction by the provider, and summarized in a report issued to the provider, the DDD director and DSS.

#### **b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The primary discovery activities that have the potential to reveal individual problems related to ISPs include complaint referrals to DHS/DDD, Biennial provider surveys, grievances, and public forums. When an individual problem is discovered, DHS/DDD takes immediate action to assess, and if necessary, ensure the safety of the participant. A support coordinator or a DHS/DDD resource coordinator may be assigned to meet with the participant to gather information critical to resolving issues and problems. As merited by the situation, DHS/DDD may request additional information from the provider. As appropriate, DHS/DDD may make a referral to Child Protective Services, Long Term Services and Supports, Law Enforcement, and/or the Medicaid Fraud Control Unit. Issues that pose a serious threat to health or safety or demonstrate continued failure to meet state requirements can result in provider sanctions to include a plan of correction, probationary status and decertification.

A1) If an ISP is found to not be reflective of the participant's personal goals the Family Support Coordinator is required to reconvene the team within 30 calendar days to update the ISP to reflect the personal goals of the participant.

A2) If an ISP is found to not address all participant health and safety risk factors the Family Support Coordinator is required to reconvene the team within 7 working days to update the ISP to address the identified areas. The Coordinator is then required to submit the plan to the DDD for review and approval. The qualified provider is also required to develop and submit a plan of correction to the DDD to remediate any deficiencies noted at a systemic level. The DDD reviews and the plan of correction and forwards to the SSMA for their review and approval.

A3) If an ISP is determined to not address all the participant's needs the Family Support Coordinator is required to reconvene the team within 30 calendar days to update the ISP. The ISP is then submitted to the DDD for review and approval.

C1 - C2) If ISPs are found to be deficient the qualified provider is required to develop and submit a plan of remediation to the DDD. The plan of remediation would detail the plan to reconvene the team within 30 calendar days to update the plan and submit to the DDD for review and approval. The DDD monitors the completion of the approved plan of remediation.

D1) If during review of an ISP it is discovered the ISP has not been monitored the qualified provider is required to develop a plan of remediation within 10 days to address each participant's plan at an individual level. When the qualified provider has their biennial review completed all individual circumstances of ISPs not being monitored as required will be reviewed and the qualified provider may be required to complete a plan of correction to address any systemic issues. The DDD approves this plan and forwards to the SSMA for review and approval. Once approved by the SSMA the qualified provider is required to complete the plan of correction. The DDD monitors the completion of the approved plan of correction.

E1, E2, E3 (Data source one for E2 and E3) The waiver administrator will complete a 100% quality assurance review of approved level of cares for participants new to the waiver. If it is determined that the choice of institution, choice of provider, or choice of waiver services are missing from a level of care the DDD will immediately notify the Family Support Coordinator and request the documentation be submitted within 24 hours. The DDD will evaluate the level of care upon receipt of this information to determine the next steps which may include voiding of claims if the start date for waiver services is affected. The Family Support 360 Waiver administrator will conduct additional training with the person responsible for completion of the level of care and the Family Support Coordinator on level of care requirements.

E2, E3 (Data source 2) If during review of a waiver participant's file/ISP it is found to not contain annual documentation of the choice of providers or choice of waiver services the qualified provider is required to develop and submit a plan of remediation to the DDD within 10 days. The plan of remediation would detail the plan to meet with the participant and/or their family within 30 calendar days to discuss choice of providers and/or waiver services. Additionally, the Support Coordinator will be provided with training to ensure a full understanding of offering waiver participants choice of providers and waiver services.

## **ii. Remediation Data Aggregation**

### **Remediation-related Data Aggregation and Analysis (including trend identification)**

<b>Responsible Party</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <div></div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <div></div>

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

**No**

**Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix E: Participant Direction of Services

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**Applicability** (*from Application Section 3, Components of the Waiver Request*):

**Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

**No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

*CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.*

**Indicate whether Independence Plus designation is requested** (*select one*):

**Yes. The state requests that this waiver be considered for Independence Plus designation.**

**No. Independence Plus designation is not requested.**

## Appendix E: Participant Direction of Services

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**E-1: Overview (1 of 13)**

**a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Family support 360 participants are supported to self-direct their services with assistance from their support coordinator. This waiver includes opportunities for participants to control and manage their supports or services by allowing the participant to:

- Develop a person-centered plan that ensures health and welfare as well as the participant's vision of a good life
- Develop an individual budget for allowable services outlined in the program guidelines
- Negotiate rates within a range for applicable services
- Serve as the employer of record, if applicable
- Recruit, hire, and manage providers
- Establish work schedules
- Train and supervise providers
- Discharge providers when necessary (or request that the co-employer do it on their behalf, if applicable)
- Participate in the development and implementation of a backup/emergency plan

The service plan is available to authorized users (the participant, people specified by the participant, providers, support coordinators, qualified providers, and DHS/DDD program specialists) via an internet application. Authorized users have access to information based on specified security levels. Plans and changes can be authorized electronically by the support coordinator at the direction of the waiver participant/family. Upon direction from the waiver participant the support coordinator is the only user with the authority to make changes to the electronic plan. Waiver participants retain view only permissions and can view their electronic support plan at any time.

Participants will be afforded the ability to self-direct Personal Care 1, Respite Care, Supported Employment and Companion Care providers. They will be supported to recruit, refer for hire, train, direct, and manage staff. Qualified providers serving in an Agency With Choice capacity will ensure that employees meet qualifications specified in the waiver and ensures compliance with all IRS and federal and state DOL regulations.

Provider rates and units of services are prescribed in the internet based service plan. Providers may view and submit time cards specific to their services. Participants and support coordinators authorize these services to be paid by the qualified provider. The support coordinator makes changes to the plan as directed by the waiver participant with support, as needed, from their family/advocate.

Participants will be supported to choose and evaluate vendors/suppliers of all waiver supplies, equipment and devices. These purchases are authorized in the service plan, and purchased through the qualified provider.

Authorized users, to include participants, will be provided real time utilization information to manage services and budgets. Participants who do not have internet access will be provided this information by support coordinators in written copy. The waiver participant is in control of and manages their budget with support from family/advocates etc.

Participants may elect to have a legal representative to direct services on their behalf. Additionally, participants may elect to not direct their own services.

Families and other people comprising the participant's natural support system may play an integral role in supporting the participant's self-direction. The support coordinator provides support, as requested, to assist the participant to self-direct services. This role is determined by each participant.

## Appendix E: Participant Direction of Services

### E-1: Overview (2 of 13)

**b. Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the waiver.  
*Select one:*

**Participant: Employer Authority.** As specified in *Appendix E-2, Item a*, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.

**Participant: Budget Authority.** As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

**Both Authorities.** The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.

**c. Availability of Participant Direction by Type of Living Arrangement.** *Check each that applies:*

**Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**

**Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**

**The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

## Appendix E: Participant Direction of Services

### E-1: Overview (3 of 13)

**d. Election of Participant Direction.** Election of participant direction is subject to the following policy (*select one*):

**Waiver is designed to support only individuals who want to direct their services.**

**The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**

**The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

*Specify the criteria*

Support coordinators are employed by qualified providers. Participants do not have the option of serving as co-employer of support coordinator. All participants have the opportunity to direct waiver services, but may choose not to direct their services. Participants who choose not to direct their services may utilize traditional qualified provider services via provider employees.

## Appendix E: Participant Direction of Services

### E-1: Overview (4 of 13)

**e. Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or

the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Support coordinators will provide participants with information to assist them in their decision making about whether to direct their services at initiation of services and when the service plan is developed or changed. A handbook was created as a means to inform the participant about the rights, responsibilities of self-direction. This handbook is available on the Division of Developmental Disabilities website and will be given to the participant by the support coordinator prior to enrollment on this waiver to ensure the participant understands the responsibilities associated with participant-direction.

They will also receive Agency With Choice job descriptions and standard hiring practices, information on wages and other conditions of employment, as well as policies and procedures specific to the program to include policies on confidentiality, drug-free workplace, grievance procedures, sexual harassment, ANE reporting, safety, universal precautions, proper lifting and back safety.

Each participant choosing participant direction must enter into an agreement acknowledging receipt of information related to rights and responsibilities to include service plan implementation, reporting requirements, billing and rates, and respective roles and responsibilities.

The information will be shared verbally (if appropriate) and in writing with accommodations made for people who are hearing-impaired or have limited English proficiency.

## Appendix E: Participant Direction of Services

### E-1: Overview (5 of 13)

**f. Participant Direction by a Representative.** Specify the state's policy concerning the direction of waiver services by a representative (*select one*):

**The state does not provide for the direction of waiver services by a representative.**

**The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: (*check each that applies*):

**Waiver services may be directed by a legal representative of the participant.**

**Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

A participant is supported to have a family member or friend, for example, assist in the management and self-direction of their personal attendant services. The support coordinator will work closely with the participant to help them identify someone to delegate these services to if needed. This is generally someone already close to the participant, and supports them to remain as independent as they are able to.

The participant who wishes to designate a non-legal representative/designee would do so by signing a form. This form outlines the functions of the authorized representative responsibilities, some of which include: show a strong commitment to the participant, show knowledge about their preferences, follow the participant's wishes and use sound judgment to act on the participant's behalf, be at least 18 years old and have known the participant for at least two years. Unless otherwise limited by the participant, the non-legal representative/designee would have direction over the individual service plan (ISP), the budget, selection of residence and providers, and negotiation of rates. If the participant objects to a decision made by the non-legal representative/designee, the participant's decision prevails. The participant may revoke the designation at any time, and the revocation should be in writing.

The non-legal representative/designee cannot be a provider, nor can they be employed by a provider, or a contractor of either. The ISP process, along with the involvement of the support coordinator, if applicable, will provide the mechanism for ensuring decisions are made in the best interests of the participant. Safeguards include the participation and watchfulness of the support coordinator as would be expected in their roles.

## Appendix E: Participant Direction of Services

### E-1: Overview (6 of 13)

**g. Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Environmental accessibility adaptations, (a.k.a., EAA)		
Supported Employment		
Specialized Medical Adaptive Equipment and Supplies (a.k.a., SMAES)		
Vehicle Modification		
Specialized Therapies		
Personal Care 1		
Nutritional Supplements		
Companion Care		
Respite		

## Appendix E: Participant Direction of Services

### E-1: Overview (7 of 13)

**h. Financial Management Services.** Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

**Yes. Financial Management Services are furnished through a third party entity.** (Complete item E-1-i).

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

**Governmental entities**

**Private entities**

**No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. Do not complete Item E-1-i.**

## Appendix E: Participant Direction of Services

### E-1: Overview (8 of 13)

- i. Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

**FMS are covered as the waiver service specified in Appendix C-1/C-3**

**The waiver service entitled:**

**FMS are provided as an administrative activity.**

#### Provide the following information

- i. Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

Fiscal Management Services are provided by qualified providers. Qualified providers are chosen to provide FMS services through an RFP process. Proposals are reviewed by a group of key stakeholders including participants and their families. They rate the proposals and make a recommendation to the DHS. DHS awards the contract if the recommended proposal meets contractual requirements. FOCOS, Inc., an internet based software service that makes the service plan and budget information available to authorized users. FOCOS was purchased through the State's approved procurement process. DHS/DDD contracts with FOCOS for their services. These costs were paid upon receipt of invoice for deliverables to include a plan of work, programming work, successful submission of a test 837, successful run of payroll, and then a monthly fee thereafter.

The qualified provider, employs support coordinators who work with participants to authorize payment of goods and services in the approved service plan via the FOCOS software.

The qualified provider also serves as the Agency with Choice. These services are authorized through the service plan software. FOCOS generates all necessary employment related forms to be downloaded by the participant or support coordinator for signature and submission. FOCOS also computes payroll deductions in a format that is downloaded into the accounting system of the Agency with Choice. The Agency with Choice then issues payroll checks, and performs other necessary bookkeeping and audit functions.

The Agency with Choice then bills the MMIS utilizing an electronic billing created by FOCOS from the services paid as authorized by the service plan.

Paper copy submissions and information are made available to participants and providers who do not have internet access.

DHS/DDD contracts with the Agency with Choice for provision of one time costs related to supporting in home providers, such as accounting system upgrades, employee handbooks, ongoing costs related to the administrative support provided by human resource management, payroll support, staff supervision, accounting services, occupancy, and cost of background checks, testing or screening. One time costs are paid after those costs are invoiced. Ongoing costs are paid upon receipt of a monthly invoice.

- ii. Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

FMS provided by qualified providers are paid a monthly fee. DHS/DDD contracts with the Agency with Choice for provision of one time costs related to supporting in home providers, such as accounting system upgrades, employee handbooks, ongoing costs related to the administrative support provided by human resource management, payroll support, staff supervision, accounting services, occupancy, and cost of background checks, testing or screening. Payment is made via a contract with DHS/DDD.

FOCOS is reimbursed for contractual deliverables for implementation, management of individual budgets and acts as the clearinghouse for the submission of claims to MMIS. DHS/DDD negotiated a contract with FOCOS based on the estimated cost of operating the FMS. The monthly fee is based on a per participant cost calculated upon the agreed cost of operating the FMS. Payment is made via this contract with FOCOS. The monthly fee is not based on the percentage of total dollar volume of transactions or utilizes the participant's funds.

**iii. Scope of FMS.** Specify the scope of the supports that FMS entities provide (*check each that applies*):

---

Supports furnished when the participant is the employer of direct support workers:

---

**Assist participant in verifying support worker citizenship status**

**Collect and process timesheets of support workers**

**Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**

**Other**

*Specify:*

Performs quarterly reporting to IRS and DOL; and  
Trains participants in worker supervision.

---

Supports furnished when the participant exercises budget authority:

---

**Maintain a separate account for each participant's participant-directed budget**

**Track and report participant funds, disbursements and the balance of participant funds**

**Process and pay invoices for goods and services approved in the service plan**

**Provide participant with periodic reports of expenditures and the status of the participant-directed budget**

**Other services and supports**

*Specify:*

Provides online authorization of timecards cross-checked by services approved in the plan of care.

---

Additional functions/activities:

---

**Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**

**Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**

**Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**

**Other**

*Specify:*

- iv. Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

Qualified waiver providers are required to conduct and submit an annual independent audit and undergo a DHS billing review.

Independent audit firms conduct the annual audit according to generally accepted accounting practices and procedures. Audits must be submitted to the DHS by November 1 and are reviewed by DHS fiscal staff to ensure compliance and identify any irregularities. Identified issues are reported to the SSMA as required in the DSS/DHS MOU.

Each provider is required to participate in a biennial billing review conducted by a DHS auditor in which a review is conducted on a random sample of claims to ensure and validate the accuracy of record keeping, supporting documentation and claim submission. The auditor generates a report of findings to the DHS waiver manager that is forwarded to the SSMA. The DHS waiver administrator may require a plan of corrective action to address identified issues. This plan is also submitted to the SSMA for review/approval.

Financial transactions and claims submission are also monitored as a component of the CMS required Payment Error Rate Measurement (PERM) process. Waiver claims are included in the sample population for PERM and are reviewed for accuracy as part of this process.

All claims adjudicated through the MMIS fall under the authority of the DSS Program Integrity (PI) Unit. The PI unit is staffed with investigators who seek and review paid claims to find inappropriate or incorrect payments to providers, and then implement any needed corrective actions.

DHS will monitor the following GCES contractual obligations annually upon contract renewal and report any negative findings to the SSMA:

- Maintain a back-up plan for processing payment in the event the computerized system is unavailable;
- Maintain a system of internal control procedures to prevent overpayments;
- Maintain a process to ensure that all time sheets are approved prior to payment and that only current employees are receiving paychecks;
- Maintain a process to ensure all providers are paid on a timely and accurate basis;
- Respond to and correct any delinquencies noted by DHS/DDD when conducting annual participant satisfaction surveys and/or program reviews;
- Comply with DHS and OMB Circular A-133 audit requirements;
- Maintain a disaster recovery plan;
- Meet DHS standards regarding HIPAA, Records Retention, Liability insurance, Drug-Free Workplace, and Confidentiality.

## Appendix E: Participant Direction of Services

### E-1: Overview (9 of 13)

- j. Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

**Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

*Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*

The support coordinator provides the participant with supports that: assist the participant during the service plan development process; assist the participant to carry out his/her employer authority (recruiting, selecting, training, directing and managing staff); and assist the participant in choosing, accessing and evaluating providers of waiver goods.

The support coordinator also: reviews the handbook with each participant to ensure understanding of their responsibilities; provides the participant information on criminal history and background check options and ensuring access to the "checks" requested by the participant; and provides the participant information on training options and considerations. Support coordinators are responsible for ensuring access to training (for service providers) as requested by the participant.

**Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Environmental accessibility adaptations, (a.k.a., EAA)	
Supported Employment	
Specialized Medical Adaptive Equipment and Supplies (a.k.a., SMAES)	
Vehicle Modification	
Support Coordination	
Specialized Therapies	
Personal Care 1	
Nutritional Supplements	
Personal Care 2	
Companion Care	
Respite	

**Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

*Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:*

Fiscal Management Services are provided by qualified providers and FOCOS Innovations, an internet based software service that makes the service plan and budget information available to authorized users. Qualified providers are chosen to provide FMS services through an RFP process. Proposals are reviewed by a group of key stakeholders including participants and their families. They rate the proposals and make a recommendation to the DHS. DHS awards the contract if the recommended proposal meets contractual requirements. FOCOS was purchased through the State's approved procurement process. FOCOS facilitates self-direction and serves as the clearing house for all approved waiver Medicaid claims. FOCOS allows for the submission of HIPAA compliant transactions to the Medicaid Management Information System for payment of all approved waiver claims.

The qualified provider also serves as the Agency with Choice. These services are authorized through the service plan software. FOCOS generates all necessary employment related forms to be downloaded by the participant or support coordinator for signature and submission. FOCOS also computes payroll deductions in a format that is downloaded into the accounting system of the Agency with Choice. The Agency with Choice then issues payroll checks, and performs other necessary bookkeeping and audit functions.

The Agency with Choice submits a claim to the MMIS utilizing an electronic billing created by FOCOS from the services paid as authorized by the service plan.

Paper copy submissions and information are made available to participants and providers who do not have internet access.

FOCOS provides all system users with support and training. Training is available via internet access, using downloadable webcasts and limited release training videos or DVDs. Contact information for FOCOS is available online or via a toll-free number. This information is distributed to participants when the plan of care is initiated and then on an ongoing basis.

FOCOS provides participants with auto-populated forms using single source database information, electronic form archiving and retrieval, and providing an online forms warehouse.

## Appendix E: Participant Direction of Services

### E-1: Overview (10 of 13)

#### k. Independent Advocacy (*select one*).

**No. Arrangements have not been made for independent advocacy.**

**Yes. Independent advocacy is available to participants who direct their services.**

*Describe the nature of this independent advocacy and how participants may access this advocacy:*

## Appendix E: Participant Direction of Services

### E-1: Overview (11 of 13)

**I. Voluntary Termination of Participant Direction.** Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

If a participant voluntarily terminates participant direction, the participant is referred to a qualified provider to receive services provided by agency employees. The agency will assist the participant in determining whether continued supports are most appropriately provided through the Family Support waiver or another waiver or service. The support coordinator ensures that this transition occurs on a timely basis and does not compromise the health and welfare of the participant.

If the participant no longer wishes to self-direct the purchase of SMAES, EAA, Vehicle Modifications, or Nutritional Supplements the support coordinator assists the waiver participant in contacting the vendor and assists with making the appropriate arrangement for these purchases. The support coordinator is knowledgeable of the participant's desired outcomes/needs and would be able to utilize this information to ensure the participant is receiving what they are needing. Conversation with the participant/family would continually be held to ensure needs are being met.

## Appendix E: Participant Direction of Services

### E-1: Overview (12 of 13)

- m. Involuntary Termination of Participant Direction.** Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

The State does not specify circumstances under which participant direction will be involuntarily terminated. If the needs of the participant become greater than the scope of the services available through the waiver and their health and safety are compromised, the support coordinator is responsible for referral to appropriate alternative services. The support coordinator is responsible for ensuring the health and welfare of the participant during service transition. The participant is afforded due process, including notice of any adverse action. In the event a participant's home or community safety or welfare is at risk the following interventions may be employed dependent on the level of jeopardy:

- \*Accessing additional natural supports;
- \*Accessing community resources such as mental health agencies or the Department of Social Services;
- \*Accessing community resources such as Long Term Services and Supports or Law Enforcement;
- \*Obtaining emergency guardianship; or
- \*Initiating a Developmental Disabilities commitment.

## Appendix E: Participant Direction of Services

### E-1: Overview (13 of 13)

- n. Goals for Participant Direction.** In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1	<input type="text"/>	<input type="text" value="1422"/>
Year 2	<input type="text"/>	<input type="text" value="1502"/>
Year 3	<input type="text"/>	<input type="text" value="1582"/>
Year 4	<input type="text"/>	<input type="text" value="1622"/>
Year 5	<input type="text"/>	<input type="text" value="1742"/>

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant Direction (1 of 6)

**a. Participant - Employer Authority** *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

**i. Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both:*

**Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

**Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

**ii. Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

**Recruit staff**

**Refer staff to agency for hiring (co-employer)**

**Select staff from worker registry**

**Hire staff common law employer**

**Verify staff qualifications**

**Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

These costs are paid by the Agency with Choice and are reimbursed by DDD as an administrative cost.

**Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

**Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

**Determine staff wages and benefits subject to state limits**

**Schedule staff**

**Orient and instruct staff in duties**

**Supervise staff**

**Evaluate staff performance**

**Verify time worked by staff and approve time sheets**

**Discharge staff (common law employer)**

**Discharge staff from providing services (co-employer)**

**Other**

Specify:

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (2 of 6)

**b. Participant - Budget Authority** *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

**i. Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

**Reallocate funds among services included in the budget**

**Determine the amount paid for services within the state's established limits**

**Substitute service providers**

**Schedule the provision of services**

**Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**

**Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**

**Identify service providers and refer for provider enrollment**

**Authorize payment for waiver goods and services**

**Review and approve provider invoices for services rendered**

**Other**

Specify:

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (3 of 6)

**b. Participant - Budget Authority**

**ii. Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Family support 360 participants are supported to self-direct their services with assistance from their support coordinator. This waiver includes opportunities for participants to control and manage their supports or services by allowing the participant to:

- Develop a person-centered plan that ensures health and welfare as well as the participant's vision of a good life
- Develop an individual budget for allowable services outlined in the program guidelines
- Negotiate rates within a range for applicable services
- Serve as the employer of record, if applicable
- Recruit, hire, and manage providers
- Establish work schedules
- Train and supervise providers
- Discharge providers when necessary (or request that the co-employer do it on their behalf, if applicable)
- Participate in the development and implementation of a backup/emergency plan

The service plan is available to authorized users (the participant, people specified by the participant, providers, support coordinators, qualified providers, and DHS/DDD program specialists) via an internet application. Authorized users have access to information based on specified security levels. Plans and changes can be authorized electronically by the support coordinator at the direction of the waiver participant/family. Upon direction from the waiver participant the support coordinator is the only user with the authority to make changes to the electronic plan. Waiver participants retain view only permissions and can view their electronic support plan at any time.

Participants will be afforded the ability to self-direct Personal Care 1, Respite Care, Supported Employment and Companion Care providers. They will be supported to recruit, refer for hire, train, direct, and manage staff. Qualified providers serving in an Agency With Choice capacity will ensure that employees meet qualifications specified in the waiver and ensures compliance with all IRS and federal and state DOL regulations.

Provider rates and units of services are prescribed in the internet based service plan. Providers may view and submit time cards specific to their services. Participants and support coordinators authorize these services to be paid by the qualified provider. The support coordinator makes changes to the plan as directed by the waiver participant with support, as needed, from their family/advocate.

Participants will be supported to choose and evaluate vendors/suppliers of all waiver supplies, equipment and devices. These purchases are authorized in the service plan, and purchased through the qualified provider.

Authorized users, to include participants, will be provided real time utilization information to manage services and budgets. Participants who do not have internet access will be provided this information by support coordinators in written copy. The waiver participant is in control of and manages their budget with support from family/advocates etc.

Participants may elect to have a legal representative to direct services on their behalf. Additionally, participants may elect to not direct their own services.

Families and other people comprising the participant's natural support system may play an integral role in supporting the participant's self-direction. The support coordinator provides support, as requested, to assist the participant to self-direct services. This role is determined by each participant.

Monies are appropriated by the Legislature for the Family Support 360 Waiver based upon estimated average cost per participant for allowable services in the approved waiver. Each qualified provider is awarded a contract based upon these averages for the number of participants supported by each program based upon the estimated units of services to support participants. Individual budgets are developed based on the needs/desires of the participant to access the necessary services and supports they have identified within their approved service plan.

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (4 of 6)

#### b. Participant - Budget Authority

- iii. Informing Participant of Budget Amount.** Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The person-directed budget is encoded in the service plan software that calculates a budget per provider, per service, and per service plan. The participant and support coordinator review this service plan prior to electronic approval.

The participant may propose budget changes at any time, by either contacting the support coordinator or updating the electronic service plan. By utilizing the electronic service plan, the overall impact of the change is calculated and the participant is able to make side by side comparisons of the proposed change. The support coordinator is then responsible for documenting the need for the change, and submitting the change to the DHS/DDD program specialist for approval. The DHS/DDD program specialist approves each plan to ensure the submitted changes to the plan continue to be allowable within the approved waiver and program guidelines. The parameters of allowable waiver services are provided to each support coordinator and available to each participant/family upon request. If the initial service plan or any subsequent changes are denied, the participant is provided notice of their right to a fair hearing and support by the support coordinator to request a hearing, if they so choose.

Paper submission / approval is available for participants who do not have internet access.

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (5 of 6)

#### b. Participant - Budget Authority

- iv. Participant Exercise of Budget Flexibility.** *Select one:*

**Modifications to the participant directed budget must be preceded by a change in the service plan.**

**The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (6 of 6)

#### b. Participant - Budget Authority

- v. Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The service plan is available to authorized users via internet and includes real time information of authorized services, year-to-date expenditure data, and remaining balance information. This information is also provided in pro forma graphs that identify the projected annual expenditures based on year-to-date expenditures, the level of spending needed to fully utilize obligated funds (in case of under-utilization) and the level of spending needed to prevent excess spending (over-utilization).

Support coordinators receive an alert when the level of over or under-utilization of funds goes beyond prescribed limits. The support coordinator is then responsible for contacting the participant and ensuring health and safety and/or making necessary revisions to the service plan.

## Appendix F: Participant Rights

### Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

**Procedures for Offering Opportunity to Request a Fair Hearing.** Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Regarding Choice of Institutional Care, applicants are informed verbally by the support coordinator and in writing via the DHS717 Home and Community Based Choice and Rights Form, of the right to a fair hearing. This form is maintained by the support coordinator and by the waiver administrator. The applicant receives a written copy of the DHS 717.

Regarding Choice of Providers, applicants are informed verbally by the support coordinator and in writing via the DHS717 Home and Community Based Choice and Rights Form, of the right to a fair hearing. This form is maintained by the support coordinator and by the waiver administrator. The form is accompanied with a listing all qualified waiver providers and support coordinators. The participant receives a copy of the DHS717 and the list of providers. Annually, participants are informed of their choice of providers verbally by the support coordinator and in writing via the DHS717 form of the right to a fair hearing. The Resource Guide is accompanied with a listing of all qualified providers and support coordinators. This form is maintained by the support coordinator.

Regarding a reduction or termination of services, participants are informed verbally by the support coordinator, and in writing via a service plan amendment/modification which includes their rights to a fair hearing. A paper copy is maintained by the support coordinator in the individual file, and a copy is given to the participant with a pamphlet explaining their rights to a fair hearing attached.

Regarding Timely Application Processing, Denial, Termination, participants/applicants are informed verbally by the support coordinator and in writing via the DSS266 Notice of Action of their right to a fair hearing. This form is maintained electronically by DSS and paper copies are maintained by the support coordinator in the individual file, by the administrator, in the individual file, and a copy is given to the participant.

The waiver has no provision for suspension of services. Waiver services continue pending a fair hearing decision.

The support coordinator or the waiver administrator may assist/support a participant who wishes to pursue a fair hearing, for example may assist the participant in writing a request and submitting it to the SSMA on their behalf

## Appendix F: Participant-Rights

### Appendix F-2: Additional Dispute Resolution Process

**a. Availability of Additional Dispute Resolution Process.** Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving

their right to a Fair Hearing. *Select one:*

**No. This Appendix does not apply**

**Yes. The state operates an additional dispute resolution process**

- b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

## Appendix F: Participant-Rights

### Appendix F-3: State Grievance/Complaint System

- a. Operation of Grievance/Complaint System.** *Select one:*

**No. This Appendix does not apply**

**Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

- b. Operational Responsibility.** Specify the state agency that is responsible for the operation of the grievance/complaint system:

Participants who serve as managing employers are afforded access to a grievance process through the provider agency. This process is outlined in the Employee Handbook. Participants are informed that the right to Medicaid fair hearing is preserved when a participant elects to make use of this process. A Medicaid fair hearing is not dependent on the participant first utilizing the grievance process. They are informed in writing via the Family Support Program Co-employer Agreement.

All qualified providers are required to maintain a grievance/complaint system as specified in ARSD 46:11:03:06 which contains minimum procedures for grievance available to all waiver participants; regardless of the choice to self-direct or not. This specifies that the waiver participant is informed that the right to a Medicaid fair hearing is preserved when a participant elects to make use of this process. Grievance procedures and appropriate implementation are reviewed by DDD during certification reviews.

In addition to each provider grievance process the State also has Administrative Rules of South Dakota 46:11:09:24 which provides for due process. All waiver participants can make a grievance directly to the Division of Developmental Disabilities at any time which affords participants due process pursuant to South Dakota Codified Law, Chapter 1-26. During the time of the grievance the participant will continue to receive any waiver services identified within the grievance.

- c. Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Family Support 360 Waiver Program and qualified provider agencies recognize the professional nature of the relationship between the participant/family and provider. Because of this professional relationship, the participant/family and provider are expected to make every attempt to resolve differences and/or problems. A grievance procedure for participants who serve as managing co-employers is outlined in the Employee Handbook given to the participant and providers of Personal Care 1, Companion Care, Respite Care and Supported Employment.

Should issues arise between the two parties, the following procedure shall be utilized:

The aggrieved party must bring the grievance to the attention of the other party either verbally or in writing. Both parties will meet to discuss the issue and potential solutions as soon as possible.

If the issue is not resolved, the aggrieved party shall have the right to submit the complaint, in writing, to the provider agency. The written complaint must also detail all previous efforts taken to resolve the issue.

After reviewing the written complaint, the provider agency will attempt to resolve the issue. This will include mediation, either by telephone or in person.

The provider agency, whose decision is final and binding, will report to both parties with a decision within ten (10) working days of mediation attempts.

In the case of adverse action, participants are informed that the right to Medicaid fair hearing is preserved when a participant elects to make use of this process.

In addition to each provider grievance process the State also has Administrative Rules of South Dakota 46:11:09:24 which provides for due process. A participant can make a grievance directly to the Division of Developmental Disabilities at any time which affords participants due process pursuant to South Dakota Codified Law, Chapter 1-26. During the time of the grievance the participant will continue to receive any waiver services identified within the grievance.

## Appendix G: Participant Safeguards

### Appendix G-1: Response to Critical Events or Incidents

- a. Critical Event or Incident Reporting and Management Process.** Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program. *Select one:*

**Yes. The state operates a Critical Event or Incident Reporting and Management Process** (*complete Items b through e*)

**No. This Appendix does not apply** (*do not complete Items b through e*)

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

- b. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

All qualified providers as required in ARSD 46:11:03:01 must have a policy on abuse, neglect and exploitation, approved by DHS/DDD which:

- 1) Defines abuse, neglect and exploitation pursuant to SDCL 22-46-1;
- 2) Requires report to DDD pursuant to ARSD 46:11:03:02;
- 3) Requires report to DSS pursuant to SDCL 26-8A-3 to 26-8A-8, inclusive;
- 4) Includes a procedure for disciplinary action to be taken if staff have engaged in abusive, neglectful, or exploitative behavior;
- 5) Includes a procedure to inform the guardian, the parent, if the participant is a minor, and the participant's advocate, if any, of the alleged incident or allegation within 24 hours after the incident or allegation, unless the person is accused of the alleged incident; and
- 6) Includes a requirement, upon substantiating the incident, to document the actions to be implemented to reduce the likelihood of or prevent repeated incidents of abuse, neglect or exploitation.

The Critical events or incidents that qualified providers are required by ARSD 46:11:09:05 to report to DHS/DDD for review and follow-up action by the appropriate authority are:

1. Death;
2. Life-threatening illness or injuries, whether hospitalization occurs or not;
3. Alleged instances of abuse, neglect, or exploitations against or by participants;
4. Changes in health or behavior that may jeopardize continued services;
5. Illnesses or injuries that result from unsafe or unsanitary conditions;
6. Any illegal activity that involves a participant.

The appropriate authority referenced above is the DHS/DDD. As need or required critical incidents will be reported to Law Enforcement, Child Protection, Long Term Services and Supports, Medicaid Fraud Control Unit, or other entities. The DHS/DDD works cooperatively with other entities to ensure the health, safety and welfare of waiver participants.

The qualified provider (typically the support coordinator) must verbally notify DHS/DDD no later than the end of the DHS/DDD's next business day or the qualified providers administrative business day whichever occurs first from the time the qualified provider becomes aware of the incident. A written report DD709 "Critical Incident Report Form" shall follow the phone or fax within 7 days.

The written report must contain an account of the incident and specify what happened, when it happened, where it happened, the participant's current status, and actions taken by the qualified provider. As appropriate, the support coordinator should identify possible causes and suggestions, plans, or actions for the prevention of similar incidents in the future. Further information relating to the incident, not available when the initial written report was completed may be submitted in the form of an addendum to this report.

Upon receipt of a report of any critical incident concerning the health, welfare, and safety of the participant, the support coordinator will make sure a plan is in place that addresses the concern within 48 hours of the incident.

At the time of certification, DHS/DDD surveys qualified providers to ensure compliance with ARSD 46:11:03:01 and 46:11:09:05.

Participant directed employees are required to report abuse, neglect and exploitation as detailed in the Family Support Providers Employee Handbook:

- 1) An employee providing services to participants through the Family Support Program/HCBS waiver is required to report alleged incidents of abuse, neglect and exploitation against children or adults with developmental disabilities. Alleged incidents involving suspected physical and or sexual abuse or neglect of a child must be reported immediately to the DSS, Child Protection Services, DSS Adult Services and Aging and/or local law enforcement. Alleged incident of abuse, neglect and exploitation against any participant will be reported immediately to the support coordinator. The support coordinator will notify DHS/DDD and DSS Child Protection Services, DSS Adult Services and Aging or local law enforcement. When an allegation involves an employee, the support coordinator will also notify the employee's employer.

**c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities

when the participant may have experienced abuse, neglect or exploitation.

The support coordinator provides information initially and annually with the family and/or participant. This includes information on stranger danger, the website of registered sex offenders, South Dakota Advocacy Services. Information is also given to families on abuse, neglect, and exploitation and where they can get training. Training for waiver participants, family members/guardians and advocates is provided at the initiation of waiver and at least annually thereafter. Training includes definitions of ANE, signs and symptoms of ANE, and how and where to report any allegation of ANE in an accessible format for the trainee. The training is provided more frequently if requested or if situations warrant additional training.

Each service plan contains the contact information for the Division of Developmental Disabilities. This information is provided and discussed with each applicant at the initiation of services and with the participant/family at least annually to inform them they may contact the State directly if they have concerns.

**d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Upon receipt of the initial report required in 46:11:09:05, the DHS/DDD program specialist will consult with the qualified provider to:

- 1) Assess the participant's immediate safety;
- 2) Ensure notification to guardian, parent, advocate, as appropriate;
- 3) Ensure appropriate reporting to DSS Child Protective Services or law enforcement if it is an allegation of abuse, neglect, or exploitation of a child;
- 4) Ensure appropriate reporting to DSS Adult Services and Aging or law enforcement if it is an allegation of abuse, neglect, or exploitation of an adult;
- 5) Ensure appropriate medical examination/treatment;
- 6) Alerting the Medicaid Fraud Control Unit as indicated by the MOU with DHS/DDD and the Attorney General's Office; and
- 8) Provision of any other technical assistance appropriate for the situation.

Upon receipt of the written report the DHS/DDD program specialist will review (within 2 days) the incident to:

- 1) Ensure appropriate reporting/notification as described above;
- 2) Forwarding the report to the Medicaid Fraud Control Unit as indicated by the MOU with the Attorney General;
- 3) Conduct follow up with collaborating agencies (DSS' Child Protective Services or Long Term Services and Supports, and/or law enforcement);
- 4) Assess the current situation to ensure the health, welfare and safety of the participant;
- 5) Assess the action of qualified provider to ensure compliance with the approved policy abuse, neglect and exploitation as required in 46:11:03:01;
- 6) Assess the qualified provider's investigation of the incident to ensure compliance with all provisions of certification; and
- 7) Conduct further review of the incident if determined that the qualified provider is not compliant with any provision of certification.

The DHS/DDD conducts internal and external quality assurance reviews of all critical incidents. One hundred percent of incidents received by DHS/DDD are reviewed by a DHS/DDD Program Specialist. The DHS/DDD Program Specialist assigned to the qualified provider receives the critical incident report and conducts the initial review. The DHS/DDD Quality Assurance Manager reviews a representative random sample of the critical incident reports. The DHS/DDD Quality Assurance Manager reviews each critical incident report to ensure that all reporting requirements were met and assess if appropriate follow-up was taken by the DHS/DDD Program Specialist and provider. Recommendations are provided to the provider's assigned Program Specialist as appropriate.

The Internal Waiver Review Committee is comprised of the each waiver manager as well as representatives from the DSS Medicaid Office and the DHS Budget and Finance Office. The Family Support Council is comprised of participants and participant family members. The Internal Waiver Review Committee and the Family Support Council will conduct an external review of critical incidents to identify trends and areas of concerns and provide recommendations to DHS/DDD.

For purposes of ensuring compliance with certification, the DHS/DDD may survey the qualified provider at any given time without prior notice (ARSD 46:11:02:18.01). This may include the DHS/DDD completing an investigation regarding a critical incident when the complaint is against the qualified provider. The DHS/DDD may impose probation, not to exceed one year, if a qualified provider has deficiencies which seriously affect the health, safety, welfare, or rights of a participant (ARSD 46:11:02:12). The qualified provider must complete, in a period approved by DHS/DDD, but not to exceed 1 year, a plan of corrective action approved by DHS/DDD (ARSD 46:11:02:13). All relevant parties are notified in writing of the results of an investigation within 15 days of the completion of an investigation.

A qualified provider's certification may be revoked (ARSD 46:11:02:14) on any of the following grounds:

- 1) Permitting, aiding, or abetting the commission of any unlawful act;
- 2) Conduct of practices detrimental to the welfare of consumers served;
- 3) Failure to comply with all licensing and other standards required by federal, state, county, city, or tribal statute, rule, or ordinance that result in practices which are detrimental to the welfare of the consumer; or
- 4) Failure to comply with a probationary plan of corrective action.

**e. Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is

conducted, and how frequently.

DHS/DDD conducts annual ARSD/HCBS service plan reviews that are a representative, random sample of all waiver participant service plans. The statistically valid sample size is based upon historical data from the previous annual ARSD/HCBS service plan review cycle. The sample size is derived by using a sample size calculator that takes into account the margin of error, the confidence level, the population size and the response distribution of previous review cycle results.

For the purposes of calculating a statistically valid sample size, a 5% margin of error, a 95% confidence level, and the most recent population size will be used. A review of the most recent review cycle results will provide the response distribution percentage.

The inspection of care specifically includes the review for possible abuse and neglect situations. This sample and DHS/DDD recommendations are referred to the SSMA for monitoring and oversight.

The DHS/DDD Quality Assurance Manager compiles and analyzes aggregate data from the CIR reporting process to identify red flags for further follow up and trends that may indicate training needs and/or service enhancements on a quarterly basis. The quarterly data is presented to the Internal Waiver Review Committee and the Family Support Council to provide oversight and further assessment of critical incidents.

All qualified providers must meet the certification requirements set forth in ARSD 46:11. DHS notifies the SSMA when and why a provider is placed on probation, when a provider satisfactorily completes a probationary plan of corrective action and/or when and why a provider's certification is revoked.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

#### **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

Support coordinators have at least quarterly contacts with participants. Initially and at least once annually, but commonly more frequently, these contacts take place in the participant's home. Because all participants reside either in their family or own home, detection of unauthorized use of restraints/seclusion must rely on these contacts, and the report/investigation of critical incidents as described in Appendix G-1.

For waiver services provided outside of the family home but in a community-based setting, for example supported employment, the same safeguards as referenced above apply.

For limited waiver services provided in a facility, for example, respite care, the above referenced safeguard continue to apply as do the certification based safeguards of each facility's licensure.

**The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

**b. Use of Restrictive Interventions.** (*Select one*):

**The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

DHS/DDD conducts annual ARSD/HCBS service plan reviews which includes a representative, random sample of service plans. The statistically valid sample size is based upon historical data from previous annual ARSD/HCBS service plan review cycle. The sample size is derived by using a sample size calculator that takes into account the margin of error, the confidence level, the population size and the response distribution of previous review cycle results.

For the purposes of calculating a statistically valid sample size, a 5% margin of error, a 95% confidence level, and the most recent population size will be used. A review of the most recent review cycle results will provide the response distribution percentage.

The unauthorized use of intervention would be detected during these reviews. Also the critical incident reporting system would require report of restrictive interventions.

**The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

- i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

- c. Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

**The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

DHS/DDD conducts annual ARSD/HCBS service plan reviews which includes a representative, random sample of service plans. The statistically valid sample size is based upon historical data from previous annual ARSD/HCBS service plan review cycle. The sample size is derived by using a sample size calculator that takes into account the margin of error, the confidence level, the population size and the response distribution of previous review cycle results.

For the purposes of calculating a statistically valid sample size, a 5% margin of error, a 95% confidence level, and the most recent population size will be used. A review of the most recent review cycle results will provide the response distribution percentage.

The unauthorized use of seclusion would be detected during these reviews. Also the critical incident reporting system would require report of restrictive interventions including seclusion.

**The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.

- i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (1 of 2)

*This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.*

- a. Applicability.** Select one:

**No. This Appendix is not applicable** *(do not complete the remaining items)*

**Yes. This Appendix applies** *(complete the remaining items)*

**b. Medication Management and Follow-Up**

- i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

- ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (2 of 2)

**c. Medication Administration by Waiver Providers**

**Answers provided in G-3-a indicate you do not need to complete this section**

- i. Provider Administration of Medications.** *Select one:*

**Not applicable.** *(do not complete the remaining items)*

**Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

- ii. State Policy.** Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- iii. Medication Error Reporting.** *Select one of the following:*

**Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**

*Complete the following three items:*

- (a) Specify state agency (or agencies) to which errors are reported:

- (b) Specify the types of medication errors that providers are required to *record*:

(c) Specify the types of medication errors that providers must *report* to the state:

**Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

**iv. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

## Appendix G: Participant Safeguards

### Quality Improvement: Health and Welfare

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

#### a. Methods for Discovery: Health and Welfare

**The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.** (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

##### i. Sub-Assurances:

**a. Sub-assurance:** *The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.* (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)

##### Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

##### Performance Measure:

**Percent of unexplained or suspicious deaths of waiver participants where further investigation was conducted as required by policy; Numerator - Number of waiver participant deaths that received further investigation as required/Denominator - Total number of participant deaths requiring further investigation.**

**Data Source** (Select one):

**Critical events and incident reports**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 250px; margin-top: 5px;"></div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 250px; margin-top: 5px;"></div>

**Performance Measure:**

**Percent of reports of abuse, neglect and exploitation which received appropriate referrals; Numerator - number of abuse, neglect and exploitation reports which received appropriate referrals/ Denominator - total number of abuse, neglect and exploitation reports.**

**Data Source** (Select one):**Critical events and incident reports**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 120px; margin-top: 5px;"></div>
<b>Other</b> Specify:	<b>Annually</b>	<b>Stratified</b> Describe Group:

<input type="text"/>		<input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

Percent of participants who received training on abuse, neglect and exploitation reporting. Numerator-Number of participant files reviewed in which the participant received abuse, neglect and exploitation training/Denominator-total number of participant files reviewed.

**Data Source** (Select one):**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 5px; width: fit-content;">             95% confidence level;              5% confidence interval           </div>
<b>Other</b> Specify:  <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<b>Other</b> Specify:  <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b>	<b>Annually</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

- b. Sub-assurance:** *The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

#### Performance Measures

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

#### Performance Measure:

**Percent of critical incidents reported timely. Numerator - Number of critical incidents reported to DHS/DDD within identified timelines/Denominator - Total number of participant critical incidents reported.**

**Data Source** (Select one):

**Critical events and incident reports**

If 'Other' is selected, specify:

**The timeliness of critical incident reporting is determined by review of each critical incident report and tracked within the operating agency.**

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative</b>

		<b>Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:****Percent of participant records in which all critical incidents were addressed.****Numerator - Number of participant records reviewed in which all critical incidents were addressed/Denominator - Total number of participant records reviewed.****Data Source** (Select one):**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <div>95% confidence level; confidence interval of 5</div>
<b>Other</b> Specify:  <div></div>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <div></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <div></div>
	<b>Other</b> Specify:  <div></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

**c. Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.**

#### **Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

#### **Performance Measure:**

**Percent of participant records in which all critical incidents were addressed.**

**Numerator - Number of participant records reviewed in which all critical incidents were addressed/Denominator - Total number of participant records reviewed.**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>

<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div>95% confidence level; Confidence interval 5</div>
<b>Other</b> Specify: <div></div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div></div>
	<b>Other</b> Specify: <div></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div></div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

- d. Sub-assurance:** *The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

#### Performance Measures

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

#### Performance Measure:

**Percent of participant records in which critical incidents involving a change in health that may jeopardize continued services were addressed. Numerator - Number of participant records reviewed in which a critical incident involving a change in health that were addressed. Denominator - Number of participant records reviewed involving a change in health that may jeopardize continued services.**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =

		95% confidence level; Confidence interval 5
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Percent of participant records in which critical incidents involving a life threatening illness or injury were addressed. Numerator - Number of participant records reviewed in which a critical incident involving a life threatening illness or injury were addressed. Denominator - Number of participant records reviewed involving a life threatening illness or injury.**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div>95%/5%</div>
<b>Other</b> Specify: <div></div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div></div>
	<b>Other</b> Specify: <div></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The DHS/DDD implemented an online review system in 2011 to compile and calculate performance measures for the Family Support 360 waiver. At the time of development and implementation the DHS/DDD utilized a response distribution rate of 50% to ensure an appropriate sample size was achieved to set the required historical baseline as the review tool and methodologies had changed. After the initial year of baseline data the DHS/DDD utilizes the previous waiver year's review results to determine the appropriate distribution rate for the following waiver year. This process is fluid and has allowed the DHS/DDD to adjust the distribution rate according to the wealth of data contained within the online review system. The aforementioned system is known as the Systemic Monitoring and Reporting Technology (SMART) system. The SMART system allows the DDD to facilitate review of compliance with SSMA oversight of the performance of waiver functions. The SMART system aligns existing quality assurance and improvement processes with federal reporting requirements while concurrently producing meaningful information for systemic improvements. The waiver administrator is responsible for aggregating information quarterly and annually for analysis by the Internal Waiver Review Committee. Their findings and recommendations are reported to the DDD Director and the SSMA for remediation. The SMART system allows the DHS/DDD to review performance data related to Participant Safeguards to monitor for individual remediation and systemic trends. The waiver administrator is responsible for completing the aggregation and analysis of this information continuously and providing the analysis to the SSMA at least quarterly or more often as requested by the SSMA. The waiver administrator presents the quality data to the SSMA during Internal Waiver Review Committee meetings. This information is also reported to the Family Support Council as requested. The SSMA can review waiver performance and corresponding data within the SMART system at any time as they have direct access to the system. Each error identified within the SMART system is remediated at an individual level and the data monitored for systemic issues. Ultimately, at the time the data is shared with the SSMA the errors and/or systemic issues have been addressed. The DDD is able to provide the SSMA remediation activities completed and necessary systemic adjustments completed. The SSMA provides additional direction as necessary to ensure compliance with the written waiver.

Critical Incident Report (CIR) system: As prescribed by administrative rule, all qualified providers are required to report critical incidents to the DHS/DDD. Each incident is reviewed by the DHS/DDD program specialist. System-wide aggregate data is analyzed by the Internal Waiver Review Committee and is provided to the Family Support Council as requested.

**b. Methods for Remediation/Fixing Individual Problems**

- i.** Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

When an individual problem is discovered, DHS/DDD takes immediate action to assess the safety of the participant. A support coordinator or a DHS/DDD resource coordinator may be assigned to meet with the participant to gather information critical to resolving issues and problems. As merited by the situation, DHS/DDD may request additional information from the provider and/or conduct an onsite investigation. As appropriate, DHS/DDD may make a referral to Child Protective Services, Long Term Services and Supports, Law Enforcement, and/or the Medicaid Fraud Control Unit. Issues that pose a serious threat to health or safety or demonstrate continued failure to meet state requirements can result in provider sanctions to include a plan of correction up to decertification.

The problem would be individually documented and systemically remediated through the discovery activity that revealed the problem. Additional information may be documented in the participant's file maintained by DDD.

A1) The DHS/DDD monitors all reported incidents of ANE to ensure that the participant is safe and appropriate referrals to outside entities (e.g. CPS, DSS, Law Enforcement) have been made. If a qualified provider has not ensured the safety of a waiver participant or made necessary referrals they will be instructed to do so. The qualified provider will be provided training on the necessity of reporting incidents to outside entities. If necessary, the DHS/DDD will ensure participant ISPs are revised.

A2) During review of waiver participant files the DHS/DDD ensures that each waiver participant has been provided training on reporting ANE. If it is discovered training has not been provided the qualified provider is required within 10 days to develop and submit a plan of remediation to the DHS/DDD which includes the timeframe to meet with the participant and provide the training.

A3) DHS/DDD completes a 100% review of waiver participant deaths. If a death report is unexplained or suspicious, the DHS/DDD may determine the death needs further investigation and take appropriate action which may include a referral to an outside entity or an on-site investigation. During analysis related to deaths it is determined further investigative activities were warranted but not completed the DHS/DDD will be required to initiate the appropriate protocol. The DHS/DDD will ensure appropriate referrals to outside entities are completed. The results of the investigative activities may lead provider sanctions including probation leading up to decertification.

B1) During review of waiver participant files information is discovered that meets the reporting requirements of a critical incident the database maintained by the DHS/DDD is reviewed to ensure the incident has been reported. If the identified incident has not been reported the DHS/DDD ensures the health and welfare of the participant. The qualified provider is required to submit a critical incident report within seven calendar days. Depending on the severity of the incident the DHS/DDD may complete additional investigative activities and a referral may be required to DSS Child Protective Service or Adult Services and Aging, law enforcement and Medicaid Fraud Control Unit. Additionally, training is provided to the qualified provider by the waiver manager regarding reportable incidents.

B2) Each critical incident received by the DHS/DDD is reviewed to determine compliance with reporting timelines. During the biennial survey of a qualified provider waiver DHS/DDD reviews the critical incident reporting database to determine if the qualified provider has reported all critical incidents within the specified timeframes, both verbal reporting and submission of the written report. A cumulative review of all the reported critical incidents may require a provider to develop a plan of correction within 30 calendar days to ensure that all future incidents are reported timely.

C1) During review of waiver participant files the DHS/DDD reviews information for the usage of unauthorized interventions or seclusion during the provision of Medicaid Waiver services. If it is discovered that unauthorized interventions or seclusion have been implemented the qualified provider is required to ensure the participant and family have the understanding of the rights of waiver participants and present the information to the Human Rights Committee for review. The qualified provider would be required to complete a critical incident report and submit to the DHS/DDD within the required timeframes. Depending on the severity of the incident a referral to DSS Child Protective Service or Long Term Services and Supports, law enforcement and Medicaid Fraud Control Unit may be required.

D1 and D3) During review of waiver participant files if information is discovered that meets the reporting requirements of a critical incident the database maintained by the DHS/DDD is reviewed to ensure the incident has been reported. If the identified incident is determined to have not been reported the DHS/DDD ensures the health and welfare of the participant. The qualified provider is required to submit a critical incident Report within seven calendar days.

D2) If an ISP is found to not address all participant health factors the Family Support Coordinator is required to reconvene the team within 7 working days to update the ISP to address the identified areas. The Coordinator is then required to submit the plan to the DDD for review and approval. The qualified provider is also required to

develop and submit a plan of correction to the DDD to remediate any deficiencies noted at a systemic level.

## ii. Remediation Data Aggregation

### Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:  <div></div>	Annually
	Continuously and Ongoing
	Other Specify:  <div></div>

## c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

### **Quality Improvement Strategy: Minimum Components**

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

## **Appendix H: Quality Improvement Strategy (2 of 3)**

### **H-1: Systems Improvement**

#### **a. System Improvements**

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The waiver's operating agency is responsible for data analysis and remediation information from the quality improvement system. The operating agency is also responsible for trending the data and providing information to the SSMA. Together the operating agency and SSMA determine system improvements or changes that may be needed. This communication facilitates ongoing discovery and remediation. The Waiver Administrator is responsible for implementation of system improvements and changes. This includes updates to both internal and external stakeholders, tracking systems changes, and potentially amending the waiver with changes to, or addition of, performance measures.

In addition to the SSAM, the operating agency also utilizes other waiver partners for assistance with data analysis, review of trended information, and development of potential system improvements. These partners include the Family Support Council, qualified provider staff, the Internal Waiver Review Committee, and Budget and Finance analysts. The Family Support Council is comprised of individuals with ID/DD and family members of individuals with ID/DD. The Family Support Council meets on a quarterly basis to review and analyze data gathered for the quality improvement strategies for the waiver and discuss issues that require attention and other items that seek to progress our efforts in achieving our mission. The IWRC consists of the waiver managers (and if appropriate a backup waiver manager) from each of the four DHS waivers (Family Support, CHOICES, HOPE, and ADLS) and a designee of the SSMA. The committee meets quarterly to review and analyze data gathered for the quality improvement strategy of each respective waiver. The committee makes recommendations and plans for systems improvement. If necessary, the operating agency may also bring together additional groups of stakeholders if significant issues are identified within the waiver operation.

Data related to the operation of the waiver is received, documented, and maintained by the Waiver Administrator. Data sources currently include Family Support 360 Waiver tracking systems, SMART system, biennial review of qualified providers, and critical incident reporting. The data collected is then recorded in the appropriate databases and spreadsheets for analysis and trending. If necessary, any immediate remediation is completed at this time. The analyzed/trended data, and any remediation completed, is reviewed by the operating agency and SSMA to identify any additional areas that may need attention. The Family Support Council and Internal Waiver Review Committee are also utilized to review the data analysis, completed remediation, and recommendations for further enhancements. Once further enhancement plans are developed, these will be shared with internal and external stakeholders through issuance of DDD Policy Memorandums approved by the SSMA.

The State continually reviews the QIS to determine if the design remains functional or if changes and improvements to the QIS are required.

## ii. System Improvement Activities

<b>Responsible Party</b> ( <i>check each that applies</i> ):	<b>Frequency of Monitoring and Analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Quality Improvement Committee</b>	<b>Annually</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Other</b> Specify:  <input type="text"/>

## b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The responsibility for monitoring the effectiveness of the waiver quality improvement strategies is continuous and ongoing. The initial steps to ensure quality begin with the support coordinator properly implementing ARSD and waiver assurances. The next steps are a quality review of waiver participant files by DHS/DDD staff to ensure compliance with ARSD and waiver assurances. The final step in the quality assurance process is the waiver administrator who has the primary responsibility of the waiver. The waiver administrator is responsible for the administration of the waiver, implementation of the quality improvement strategies, and assessment of their effectiveness. The waiver administrator provides this information to the SSMA agency and other partners for assistance with remediation and potential changes to the quality improvement strategies. The DDD Director is very important in the overall waiver operations to ensure the quality improvement strategies function as necessary to meet waiver participants' needs as well as CMS and other regulatory standards. If changes are determined necessary the operating agency and SSMA will design the changes. The Waiver administrator will implement the changes and collect and analyze the data to determine if the system changes were successful. Effectiveness of the changes will be determined by data indicating a positive or negative change in the overall discovery data. The analysis will be presented to the DHS/DDD administration, the SSMA and the Internal Waiver Review Committee for continued trending. Any enhancement plans developed as a result of trending analysis will be shared with internal and external stakeholders through issuance of Policy Memorandums.

**ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.**

Information vital to the success of the waiver is gathered through many forms, SMART system, critical incident reporting, biennial provider reviews, and waiver tracking systems. This information is directly related to the waivers quality improvement system. The quality improvement system is evaluated at each juncture of the continuous quality improvement cycle:

Discovery;  
Remediation;  
Implementation/Improvement.

This continuous cycle will provide the avenue necessary to determine the effectiveness of the quality system. If the quality system is not effective this will be apparent through repeated issues and problems. These will be the indicators of the necessity for changes to the quality system. The DHS/DDD administration, SSMA, Family Support Council, Internal Waiver Review Committee, and other stakeholders will play a vital role in the development of improvements to the quality strategy. At a minimum all aspects of the quality improvement system will be reviewed annually to review the collected and analyzed data. If analysis shows a need for system improvements prior to an annual review this will be completed as described in H.1.a.i and H.1.b.i.

## Appendix H: Quality Improvement Strategy (3 of 3)

### H-2: Use of a Patient Experience of Care/Quality of Life Survey

**a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):**

No

Yes (*Complete item H.2b*)

**b. Specify the type of survey tool the state uses:**

HCBS CAHPS Survey :

NCI Survey :

NCI AD Survey :

Other (*Please provide a description of the survey tool used*):

## ***Appendix I: Financial Accountability***

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### ***I-1: Financial Integrity and Accountability***

***Financial Integrity.*** Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

*Qualified providers are required to:*

- 1) Undergo and submit an annual audit;*
- 2) Undergo a representative random sample review of all claims; and*
- 3) Submit to monitoring conducted by DHS as a component of the Payment Error Rate Measurement (PERM).*

*According to the contractual arrangement with qualified waiver providers, each provider is required to undergo and submit an annual, entity-wide audit conducted by an independent, third party audit firm in accordance with generally accepted accounting principles. These audits are received, reviewed and analyzed by DHS fiscal staff. Issues/concerns are reported to DHS/DDD for follow-up.*

*Qualified providers are required to participate in a billing review process conducted by a DHS analyst, in which a review is conducted on a representative random sample of participants' claims to ensure and validate the accuracy of record keeping, supporting documentation, and the resulting claims submitted for payment. The sample size is derived by using a sample size calculator that takes into account the margin of error, the confidence level, the population size and the response distribution. The response distribution is calculated each cycle, using the previous review cycle results. Claims submitted for payment in the preceding twelve months of the month the billing review is completed are subject to the claims sample. As described in the quality improvement section one-half of the qualified providers are reviewed in one waiver year and the other half in the next waiver year to ensure all providers have participated in a billing review within a two year period. Additionally, as described in the quality improvement section any qualified provider with a billing error greater than five percent will have a follow-up audit review within four months.*

*For the purposes of calculating a statistically valid sample size, a 5% margin of error, a 95% confidence level, and the most recent review cycle's population size will be used. A review of the most recent review cycle results will provide the response distribution percentage.*

*Findings are compiled, reviewed by the waiver administrator, if appropriate addressed in a plan of correction, and summarized in a report issued to the provider, the DHS/DDD director and SSMA.*

*Financial transactions and claims submissions are also monitored as a component of the PERM process. Waiver claims are included in the sample population for PERM and are reviewed for accuracy as part of this process.*

*All claims adjudicated through the MMIS fall under the authority of the DSS Program Integrity (PI) unit. The PI unit is staffed with investigators who seek and review to find inappropriate or incorrect payments to providers. The PI unit communicates any issues identified through the review process with the DHS/DDD via e-mail. The PI unit will communicate the findings of the review with the providers and request refund checks if appropriate*

*The Department of Legislative Audit (DLA) conducts the State of South Dakota's annual independent audit and ensuring that it complies with the Single Audit Act (31 U.S.C. 7501-7507) as amended by the Single Audit Act Amendments of 1996 (P.L. 104-146). DLA is under the Legislative Branch of state government, therefore independent of the Executive Branch. DLA audits are conducted in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in Government Auditing Standards issued by the Comptroller General of the United States. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. In accordance with Government Auditing Standards, DLA also reviews internal controls over financial reporting and tests compliance with certain provisions of laws, regulations, contracts, and grant agreements.*

*Upon completion of the Single State Audit, DLA submits copies to each department secretary and director of budget and finance. The DHS' Office of Budget & Finance is responsible for coordinating all responses to the Single State Audit and gathers all pertinent information for any necessary response.*

## **Appendix I: Financial Accountability**

### **Quality Improvement: Financial Accountability**

*As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.*

#### **a. Methods for Discovery: Financial Accountability Assurance:**

***The State must demonstrate that it has designed and implemented an adequate system for ensuring financial***

**accountability of the waiver program.** (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

**i. Sub-Assurances:**

**a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.**

(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

**Performance Measures**

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

**Number and percent of claims paid accurately for an approved service for eligible waiver participants. Numerator - The number of sampled claims that are correct.**

**Denominator - The total number of sampled claims.**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:

		<div> Proportionate sample; 95% Confidence level; Confidence Interval of 5 </div>
	<b>Other Specify:</b> <div> All providers will be reviewed in a two year period, 1/2 in one year and 1/2 in the next year. </div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other Specify:</b> <div></div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other Specify:</b> <div></div>

- b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.**

**Performance Measures**

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the

method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

**Percentage of provider payment rates that are consistent with rate methodology approved in the approved waiver. Numerator - Number of provider payments that are consistent with rate methodology and appropriate rate. Denominator - Total number of reviewed payments.**

**Data Source (Select one):**

**Record reviews, off-site**

**If 'Other' is selected, specify:**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other Specify:</b> <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other Specify:</b> <div>Proportionate sample: 95% confidence level; Confidence interval 5</div>
	<b>Other Specify:</b>	

	All providers will be reviewed in a two year period, 1/2 in one year and 1/2 in the next year.	
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**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

A DHS management analyst performs a review of payments for waiver services to ensure each claim billed meets waiver qualifications. All claims billed in the sampling period are susceptible for review. The provider is informed of the review dates(s) and the sampled claims. The analyst reviews documentation of services and if necessary, requests clarification or additional information from the provider. The analyst reviews all documentation to ensure payment was correct according to processing and payment methodologies and to ensure the claim was billed and paid according to the services authorized by the program rules.

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

*Claims Reviews serve as the primary discovery activity for individual problems related to financial accountability. Claims review findings are summarized in a report issued to the provider, the DHS/DDD director, the Waiver Manager, and SSMA. An error rate is calculated based on the total dollars found in error versus the total dollars reviewed. The provider is required to complete individual claims adjustments within 60 days of the date they receive the report of findings from the review. If a provider is found to have an error rate greater than five percent this results in a follow-up review approximately four months later. The DHS management analyst tracks each incorrect claim to ensure an appropriate adjustment is made. The DHS management analyst follows up with the provider if the adjustment is not made.*

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

<b>Responsible Party</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div></div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div></div>

**c. Timelines**

*When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.*

**No**

**Yes**

*Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.*

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (1 of 3)

**a. Rate Determination Methods.** *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

*Rates are established by DHS for the waiver service - support coordination. Current support coordination rates are established based on cost information and time study data. Cost information includes the support coordinator salary, benefits, travel and phone expenses, supplies, dues, equipment, and fees.*

*Time study data indicates how many billable units of service can be produced annually. Annually one full time equivalent (FTE) is paid for 2080 hours. Time study data was used to identify the number of billable units that a support coordinator could produce, by identifying time spent on non-billable activities, such as vacation, annual and sick leave, travel time (which can be extensive in frontier areas of the state), meeting and training time, etc. From the time study, 41% of time was spent on support coordination for waiver recipients and 14% of time was spent on support coordination for non-waiver recipients. Of the total hours, 55% of total time was billable time spent on support coordination. 41% of the total hours produced 853 hours of billable waiver time; 14% of the total hours produced 291 hours of billable general funded time. Adding the billable waiver time and billable general funded time, 1,144 hour is billable support coordination time. Of the 2,080 total hours, 55% of the time is billable support coordination time. At the time of the completion of the time study there were 12 FTE which showed 1,144 total billable support coordination hours per FTE. The 1,144 total billable support coordination hours was multiplied by 12 FTE to amount to 13,728 total billable support coordination hours. The total administrative costs for the 12 FTE were determined and divided by the billable support coordination hours of 13,728 to produce a billable per hour rate of \$54.27. The rate was then inflated by 5% for FY06 to \$56.98 (rounded to \$57.00). The per unit rate of \$57.00 was then divided by four to produce the FY06 support coordination rate of \$14.25. This rate is indexed for inflation when funding is appropriated by the State Legislature. When the rate for service coordination is indexed for inflation as described the Family Support Council is apprised of the proposed rate change. The opportunity for public comment and input are provided through posting of information on the State's website and conducting public forums. Sharing of the information with stakeholders, the administrative agency, and the legislature allows the opportunity to determine if a rate rebase is necessary. Additionally, the budget is presented to the public annually through the legislative process. This process is open for public attendance and comment. The current support coordination rate is comparable or exceeds other rates within South Dakota for case management services. Information related to the support coordination rate is posted at <http://dss.sd.gov/medicaid/providers/feeschedules/dhs/>*

*Rates for Personal Care 1, Respite and Companion Care and Supported Employment are negotiated by the participant with the support of the Agency with Choice (See Appendix E). The waiver utilizes an Agency with Choice model thereby allowing the waiver participant /family to be co-employer of providers. The Agency with Choice is responsible to ensure appropriate background checks are completed and the provider is clear for employment. Participants must follow the standard DOL Fair Labor Standards Act including state and federal minimum wage requirements. If a participant chooses not to self-direct, an agency will charge rates based on unit costs as determined by annual cost report. The state does not set these rates.*

*Rates for Personal Care 2, which is an extended state plan service, are paid at the rate established within the state plan. The SSMA is responsible for the rate establishment of state plan personal care services.*

*Supplies/Vendor services (EAA, SMAES, Nutritional Supplements, Vehicle Modifications) are provided at market/retail rates; there are no rate methodologies for these services. There is not a maximum allowable rate determined by the state for these services nor a frequency limit. As these services are purchased at market rate the state does not perform bids or review past claims. Additionally, given these services are purchased at market rate the state does not set rates.*

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

*Support Coordination is billed by the qualified provider employer via an electronic billing submitted by the qualified provider to DSS MMIS.*

*Billings for Personal Care 1, Respite, Companion Care and Supported Employment services that are provided by an individual who is an employee under the immediate co-supervision of the Agency With Choice flow through the FOCoS database. FOCoS provides administrative support to the Agency With Choice by ensuring the time cards submitted by the service provider are consistent with the authorized services in the service plan. The time card must be approved by the Agency With Choice and the participant. The Agency With Choice issues payment to the employee and then electronically bills the DSS MMIS. FOCoS and Agency With Choice are the entities described in Appendix C and E.*

*Participants receiving EAA, Nutritional Supplements, SMAES, or Vehicle Modifications must authorize this through their service plan. The support coordinator assists the waiver participant to secure the appropriate vendor for the waiver service to be provided. Upon the waiver participant's decision the support coordinator updates the service plan as required and submits the plan to the DDD program specialist for review and approval. Once the plan has been authorized by the DDD program specialist the vendor will submit the invoice to the support coordinator. Upon receipt of the invoice the support coordinator, utilizing the FOCoS system, will bill the DSS MMIS.*

*SSMA exercises administrative authority and oversight of the waiver and authorizes and pays all waiver claims through the DSS MMIS.*

## **Appendix I: Financial Accountability**

### **I-2: Rates, Billing and Claims (2 of 3)**

#### **c. Certifying Public Expenditures (select one):**

***No. state or local government agencies do not certify expenditures for waiver services.***

***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

**Select at least one:**

#### ***Certified Public Expenditures (CPE) of State Public Agencies.***

*Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-a.)*

#### ***Certified Public Expenditures (CPE) of Local Government Agencies.***

*Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)*

## **Appendix I: Financial Accountability**

### **I-2: Rates, Billing and Claims (3 of 3)**

**d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

a) When an applicant / participant does not meet the waiver level of care, the DSS benefits specialist updates the MMIS reflecting the appropriate period of eligibility/ineligibility. The MMIS will only pay those waiver claims submitted for a participant with a date of service within level of care eligibility timeframes.

b) Support coordinators and in-home providers may only enter time cards or other billing requests for services in the internet application for approved services/providers as designated by the service plan.

c) Following provider submission of time cards or other billing, the participant must authorize payment via the internet application or written acknowledgement that the service was provided to the qualified provider. The qualified provider may only bill the MMIS after this authorization is completed.

d) A management analyst within DHS performs an internal review of payments for waiver services. The analyst selects a random sample of claims from each provider and reviews the associated services billed during a specified time period. The provider is informed of the review date and the sampled participants. The analyst reviews documentation of services (service plan, case notes, etc.) and if necessary, requests clarification or additional information from the provider. The analyst reviews all documentation to ensure payment was correct according to processing and payment methodologies and to ensure the claim was billed and paid according to the services authorized by the program rules. The review findings are summarized in a report issued to the provider, the DHS/DDD Director, waiver administrator and the SSMA. Identified errors are addressed and corrected.

**e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

## Appendix I: Financial Accountability

### I-3: Payment (1 of 7)

**a. Method of payments -- MMIS (select one):**

**Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**

**Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

**Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

**Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

*Describe how payments are made to the managed care entity or entities:*

## **Appendix I: Financial Accountability**

### **I-3: Payment (2 of 7)**

**b. Direct payment.** *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

*Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:*

***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

*Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.*

## **Appendix I: Financial Accountability**

### **I-3: Payment (3 of 7)**

**c. Supplemental or Enhanced Payments.** *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

***No. The state does not make supplemental or enhanced payments for waiver services.***

***Yes. The state makes supplemental or enhanced payments for waiver services.***

*Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.*

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**Appendix I: Financial Accountability**

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**I-3: Payment (4 of 7)**

**d. Payments to state or Local Government Providers.** Specify whether state or local government providers receive payment for the provision of waiver services.

**No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.**

**Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.**

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

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**Appendix I: Financial Accountability**

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**I-3: Payment (5 of 7)**

**e. Amount of Payment to State or Local Government Providers.**

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

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**Answers provided in Appendix I-3-d indicate that you do not need to complete this section.**

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**The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.**

**The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**

**The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

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**Appendix I: Financial Accountability**

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**I-3: Payment (6 of 7)**

**f. Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***

***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

*Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.*

## ***Appendix I: Financial Accountability***

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### ***I-3: Payment (7 of 7)***

#### ***g. Additional Payment Arrangements***

##### ***i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:***

***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***

***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

*Specify the governmental agency (or agencies) to which reassignment may be made.*

##### ***ii. Organized Health Care Delivery System. Select one:***

***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***

***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

*Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:*

Entities are designated as an OHCDs when they meet the criteria outlined in ARSD 46:11:09:02. This includes being certified as a community support provider, having a signed provider agreement with the Department of Social Services and the Division of Development Disabilities, and provide at least one service covered under the provisions of article 67:16. If a provider does not voluntarily agree to contract with an OHCDs they are able to provide services upon meeting the criteria as described in ARSD 46:11:09:03 which includes having a signed provider agreement with the Department of Human Services and the Department of Social Services, be able to meet the requirements for the service being provided, ensure employees meet qualifications, and have policies to ensure the health and safety of the participant. Each participant is informed upon application and annually of their right to choose their provider. The Division of Developmental Disabilities ensures this information is provided to each participant at the time of application during review of the application for waiver services. To ensure this information is provided to the participant annually the Division of Developmental Disabilities reviews for this during the representative random sample participant file review process. Currently participants are choosing to utilize the Agency with Choice model or a sub-contractual relationship between an OHCDs and another provider or OHCDs. Financial accountability is maintained at several levels. The OHCDs is required to complete an annual contract with the Department of Human Services that provides detailed instructions as to how waiver funding may be utilized. Participant plans are reviewed at the state level to ensure that waiver funding is assigned to participants to pay for supports and services that meet waiver requirements. Each OHCDs is required to conduct and submit an annual audit, undergo a representative random sample review of all claims, and submit to monitoring conducted by DHS as a component of the PERM. All claims adjudicated through the MMIS fall under the authority of the DSS Program Integrity unit. This system is staffed with investigators who seek and review paid claims to find inappropriate or incorrect payment to providers. The Department of Human Services continually reviews the ARSD associated with the Family Support 360 program and those ARSD that coincide with this waiver application. DHS will bring together various stake holders to assist with review and updates to the ARSD. Once ARSD have been promulgated this waiver application may be amended to address changes as a result of the ARSD promulgation process.

**iii. Contracts with MCOs, PIHPs or PAHPs.**

***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***

***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

*Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.*

***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***

***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***

***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

*In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may*

*voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.*

## **Appendix I: Financial Accountability**

### **I-4: Non-Federal Matching Funds (1 of 3)**

**a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

**Appropriation of State Tax Revenues to the State Medicaid agency**

**Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

*If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:*

*The non-Federal share of waiver costs is appropriated by the South Dakota Legislature to DHS DDD.*

*The DSS MMIS reimburses claims utilizing DHS accounting coding. As payments are made the expenses for both the Federal & non-Federal share are posted to the applicable DHS budget centers. DSS reimburses DHS the Federal share after they draw the Federal cash. DHS verifies/certifies expenditures on a quarterly basis by providing an accounting report to DSS. In turn, DSS prepares the Federal CMS 64 report.*

**Other State Level Source(s) of Funds.**

*Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:*

## **Appendix I: Financial Accountability**

### **I-4: Non-Federal Matching Funds (2 of 3)**

**b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

**Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.

**Applicable**

Check each that applies:

**Appropriation of Local Government Revenues.**

*Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the*

source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

**Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (3 of 3)

- c. Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

*None of the specified sources of funds contribute to the non-federal share of computable waiver costs*

*The following source(s) are used*

Check each that applies:

*Health care-related taxes or fees*

*Provider-related donations*

*Federal funds*

For each source of funds indicated above, describe the source of the funds in detail:

## Appendix I: Financial Accountability

### I-5: Exclusion of Medicaid Payment for Room and Board

- a. Services Furnished in Residential Settings.** Select one:

*No services under this waiver are furnished in residential settings other than the private residence of the individual.*

*As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.*

- b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:

*The waiver does not provide residential services. All participants live in their own homes or with family members. These are not provider funded or staffed homes which prevent room and board costs from being included in rate costs. FFP may be claimed only for the cost of room and board when provided as part of respite care in a Medicaid certified NF or ICF/IID, or when it is provided in a foster home or community residential facility that meets State standards specified in this waiver.*

## **Appendix I: Financial Accountability**

### **I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver**

**Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.** Select one:

**No.** *The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.*

**Yes.** *Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.*

*The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:*

## **Appendix I: Financial Accountability**

### **I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)**

**a. Co-Payment Requirements.** *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

**No.** *The state does not impose a co-payment or similar charge upon participants for waiver services.*

**Yes.** *The state imposes a co-payment or similar charge upon participants for one or more waiver services.*

#### **i. Co-Pay Arrangement.**

*Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):*

**Charges Associated with the Provision of Waiver Services** (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

**Nominal deductible**

**Coinsurance**

**Co-Payment**

**Other charge**

*Specify:*

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## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

#### a. Co-Payment Requirements.

##### ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

#### a. Co-Payment Requirements.

##### iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

#### a. Co-Payment Requirements.

##### iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

#### b. Other State Requirement for Cost Sharing. Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

**No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**

**Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

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## Appendix J: Cost Neutrality Demonstration

### J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

**Composite Overview.** Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor

D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

**Level(s) of Care: ICF/IID**

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	4279.78	13508.12	17787.90	204543.60	4836.98	209380.58	191592.68
2	4214.50	13778.28	17992.78	208634.50	4933.72	213568.22	195575.44
3	4265.10	14053.85	18318.95	212807.20	5032.39	217839.59	199520.64
4	4410.64	14334.93	18745.57	217063.30	5133.04	222196.34	203450.77
5	4486.15	14621.63	19107.78	221404.60	5234.70	226639.30	207531.52

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (1 of 9)

**a. Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

**Table: J-2-a: Unduplicated Participants**

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		ICF/IID	
Year 1	1422		1422
Year 2	1502		1502
Year 3	1582		1582
Year 4	1622		1622
Year 5	1742		1742

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (2 of 9)

**b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay is calculated by using the unduplicated count of participants on the waiver divided by the total days of waiver coverage. The length of stay from the WY 3, 372 report, of the approved 2017 - 2022 waiver is being utilized; 341.6. The number will be adjusted based on actual data for future 372 reports, amendments, and renewals.

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (3 of 9)

**c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

**i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

*Estimated average HCBS utilization and expenditures approved in the WY3 372 report was utilized to develop estimates of waiver services. Service specific data was analyzed to determine the number of participants utilizing each waiver service as well as an estimated number of units per waiver participant. The WY3 372 expenditures were then increased by 2% to account for WY 4-5 and the estimate of WY5 was increase by 2% to arrive at the projected expenditure estimates in waiver year one. An annual increase of 2% was applied to each waiver service during the subsequent waiver years. The 2% increase was arrived at by review of 372 reports from WY1-3 of the 2017-2022 waiver which revealed an overall increase from WY1 to WY3 of approximately 2% in factor d. The state utilized the unduplicated waiver participant count from WY5 and increased this number by 80 for WY1. The additional 80 projected waiver participants are due to additional appropriated funding during the most recent legislative session. Once these projections were arrived at the waiver application was completed utilizing this data thereby arriving at factor d as shown in the waiver application.*

- ii. Factor D' Derivation.** *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

*The estimated annual average per capita Medicaid cost for state plan services provided to participants on the waiver program from approved 372 reports for WY1 through WY3 of 2017 - 2022 approved waiver were utilized as the base factor d' to begin the estimate process. Review of 372 reports from the approved 2017 - 2022 waiver were analyzed showing an approximate increase of 2% in factor D' each year. This noted annual increase was applied to the WY3 372 factor d' to account for WY4 and WY5 and the estimated factor d' for WY5 was utilized as the estimate factor d' for this waiver renewal. Factor d' was then adjusted by 2% in each subsequent waiver year of this renewal.*

- iii. Factor G Derivation.** *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

*The estimated annual average per capita Medicaid cost for ICF/IID for (that would be incurred for participants served on the waiver, were the waiver not granted) from approved 372 reports for WY1 through WY3 of 2017 - 2022 approved waiver were utilized as the base factor g to begin the estimate process. Review of 372 reports from the approved 2017 - 2022 waiver were analyzed showing an approximate increase of 2% in factor g each year. This noted annual increase was applied to the WY3 factor g to account for WY4 and WY5. The 2% trend factor was then applied to WY5 and was utilized as the estimate for WY1 for factor g for this renewal. Factor g was then adjusted by 2% in each subsequent waiver year of this renewal.*

- iv. Factor G' Derivation.** *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

*The estimated annual average per capita Medicaid costs for state plan services (other than those included in Factor G for participants served on the waiver were the waiver not granted) from approved 372 reports for WY1 through WY3 of the 2017-2022 approved waiver were utilized as the base factor g' to begin the estimate process. Review of 372 reports from the approved 2012 - 2017 waiver were analyzed showing an approximate increase of 2% in factor g' each year. This noted annual increase was applied to the WY3 factor g' to account for WY4 and WY5. The 2% trend factor was then applied to WY5 to arrive at the estimate factor g' for year one of this renewal. Factor g' was then adjusted by 2% in each subsequent year of this renewal.*

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (4 of 9)

**Component management for waiver services.** *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “manage components” to add these components.*

Waiver Services	
Personal Care 1	
Respite	
Support Coordination	

<b>Waiver Services</b>	
<b>Supported Employment</b>	
<b>Personal Care 2</b>	
<b>Companion Care</b>	
<b>Environmental accessibility adaptations, (a.k.a., EAA)</b>	
<b>Nutritional Supplements</b>	
<b>Specialized Medical Adaptive Equipment and Supplies (a.k.a., SMAES)</b>	
<b>Specialized Therapies</b>	
<b>Vehicle Modification</b>	

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (5 of 9)

#### d. Estimate of Factor D.

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Personal Care 1 Total:</b>						562473.02
Personal Care 1	15 minutes	96	607.16	9.65	562473.02	
<b>Respite Total:</b>						670367.65
Respite	15 minutes	865	80.31	9.65	670367.65	
<b>Support Coordination Total:</b>						2363819.04
Support Coordination	15 minutes	1422	88.00	18.89	2363819.04	
<b>Supported Employment Total:</b>						28118.17
Supported Employment	15 minutes	17	171.40	9.65	28118.17	
<b>Personal Care 2 Total:</b>						5446.80
Personal Care 2	15 minutes	8	85.00	8.01	5446.80	
<b>Companion Care Total:</b>						1392745.90
Companion Care	15 minutes	455	317.20	9.65	1392745.90	
<b>Environmental accessibility adaptations, (a.k.a., EAA) Total:</b>						203007.02
Environmental					203007.02	
<b>GRAND TOTAL:</b>						6085852.21
Total Estimated Unduplicated Participants:						1422
Factor D (Divide total by number of participants):						4279.78
Average Length of Stay on the Waiver:						341

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
accessibility adaptations, (a.k.a., EAA)	unit	99	4.40	466.04		
<b>Nutritional Supplements Total:</b>						15021.56
Nutritional Supplements	unit	37	4.40	92.27	15021.56	
<b>Specialized Medical Adaptive Equipment and Supplies (a.k.a., SMAES) Total:</b>						353966.65
Specialized Medical Adaptive Equipment and Supplies (a.k.a., SMAES)	unit	865	1.00	409.21	353966.65	
<b>Specialized Therapies Total:</b>						345000.00
Specialized Therapies	unit	230	12.00	125.00	345000.00	
<b>Vehicle Modification Total:</b>						145886.40
Vehicle Modification	unit	15	1.00	9725.76	145886.40	
<b>GRAND TOTAL:</b> Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						6085852.21 1422 4279.78 341

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (6 of 9)

#### d. Estimate of Factor D.

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Personal Care 1 Total:</b>						590823.12
Personal Care 1	15 minutes	97	619.00	9.84	590823.12	
<b>Respite Total:</b>						492462.58
Respite	15 minutes	611	81.91	9.84	492462.58	
<b>Support Coordination Total:</b>						2597972.15
<b>GRAND TOTAL:</b> Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						6330176.13 1502 4214.50 341

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Support Coordination	15 minutes	1502	89.76	19.27	2597972.15	
<b>Supported Employment Total:</b>						29243.89
Supported Employment	15 minutes	17	174.82	9.84	29243.89	
<b>Personal Care 2 Total:</b>						5666.71
Personal Care 2	15 minutes	8	86.70	8.17	5666.71	
<b>Companion Care Total:</b>						1477205.99
Companion Care	15 minutes	464	323.54	9.84	1477205.99	
<b>Environmental accessibility adaptations, (a.k.a., EAA) Total:</b>						251328.00
Environmental accessibility adaptations, (a.k.a., EAA)	unit	100	4.48	561.00	251328.00	
<b>Nutritional Supplements Total:</b>						16022.99
Nutritional Supplements	unit	38	4.48	94.12	16022.99	
<b>Specialized Medical Adaptive Equipment and Supplies (a.k.a., SMAES) Total:</b>						368146.80
Specialized Medical Adaptive Equipment and Supplies (a.k.a., SMAES)	unit	882	1.00	417.40	368146.80	
<b>Specialized Therapies Total:</b>						352500.00
Specialized Therapies	unit	235	12.00	125.00	352500.00	
<b>Vehicle Modification Total:</b>						148803.90
Vehicle Modification	unit	15	1.00	9920.26	148803.90	
<b>GRAND TOTAL:</b>					6330176.13	
Total Estimated Unduplicated Participants:					1502	
Factor D (Divide total by number of participants):					4214.50	
Average Length of Stay on the Waiver:						341

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (7 of 9)

#### d. Estimate of Factor D.

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Personal Care 1 Total:</b>						627874.59
Personal Care 1	15 minutes	99	631.69	10.04	627874.59	
<b>Respite Total:</b>						523437.41
Respite	15 minutes	624	83.55	10.04	523437.41	
<b>Support Coordination Total:</b>						2847399.09
Support Coordination	15 minutes	1582	91.55	19.66	2847399.09	
<b>Supported Employment Total:</b>						32225.99
Supported Employment	15 minutes	18	178.32	10.04	32225.99	
<b>Personal Care 2 Total:</b>						6629.60
Personal Care 2	15 minutes	9	88.43	8.33	6629.60	
<b>Companion Care Total:</b>						1570504.39
Companion Care	15 minutes	474	330.01	10.04	1570504.39	
<b>Environmental accessibility adaptations, (a.k.a., EAA) Total:</b>						228732.57
Environmental accessibility adaptations, (a.k.a., EAA)	unit	103	4.58	484.87	228732.57	
<b>Nutritional Supplements Total:</b>						17145.73
Nutritional Supplements	unit	39	4.58	95.99	17145.73	
<b>Specialized Medical Adaptive Equipment and Supplies (a.k.a., SMAES) Total:</b>						383166.00
Specialized Medical Adaptive Equipment and Supplies (a.k.a., SMAES)	unit	900	1.00	425.74	383166.00	
<b>Specialized Therapies Total:</b>						358500.00
Specialized Therapies	unit	239	12.00	125.00	358500.00	
<b>Vehicle Modification Total:</b>						151780.20
Vehicle Modification	unit	15	1.00	10118.68	151780.20	
<b>GRAND TOTAL:</b>						6747395.57
Total Estimated Unduplicated Participants:						1582
Factor D (Divide total by number of participants):						4265.10
Average Length of Stay on the Waiver:						341

## Appendix J: Cost Neutrality Demonstration

**J-2: Derivation of Estimates (8 of 9)****d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 4**

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Personal Care 1 Total:</b>						666381.52
Personal Care 1	15 minutes	101	644.32	10.24	666381.52	
<b>Respite Total:</b>						555072.31
Respite	15 minutes	636	85.23	10.24	555072.31	
<b>Support Coordination Total:</b>						3037145.53
Support Coordination	15 minutes	1622	93.39	20.05	3037145.53	
<b>Supported Employment Total:</b>						33525.96
Supported Employment	15 minutes	18	181.89	10.24	33525.96	
<b>Personal Care 2 Total:</b>						6900.30
Personal Care 2	15 minutes	9	90.20	8.50	6900.30	
<b>Companion Care Total:</b>						1664895.59
Companion Care	15 minutes	483	336.62	10.24	1664895.59	
<b>Environmental accessibility adaptations, (a.k.a., EAA) Total:</b>						242512.40
Environmental accessibility adaptations, (a.k.a., EAA)	unit	105	4.67	494.57	242512.40	
<b>Nutritional Supplements Total:</b>						17834.17
Nutritional Supplements	unit	39	4.67	97.92	17834.17	
<b>Specialized Medical Adaptive Equipment and Supplies (a.k.a., SMAES) Total:</b>						398650.68
Specialized Medical Adaptive Equipment and Supplies (a.k.a., SMAES)	unit	918	1.00	434.26	398650.68	
<b>GRAND TOTAL:</b>						7154055.26
Total Estimated Unduplicated Participants:						1622
Factor D (Divide total by number of participants):						4410.64
Average Length of Stay on the Waiver:						341

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Specialized Therapies Total:</b>						366000.00
Specialized Therapies	unit	244	12.00	125.00	366000.00	
<b>Vehicle Modification Total:</b>						165136.80
Vehicle Modification	unit	16	1.00	10321.05	165136.80	
<b>GRAND TOTAL:</b>						7154055.26
Total Estimated Unduplicated Participants:						1622
Factor D (Divide total by number of participants):						4410.64
Average Length of Stay on the Waiver:						341

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (9 of 9)

#### d. Estimate of Factor D.

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Personal Care 1 Total:</b>						707387.98
Personal Care 1	15 minutes	103	657.21	10.45	707387.98	
<b>Respite Total:</b>						589563.61
Respite	15 minutes	649	86.93	10.45	589563.61	
<b>Support Coordination Total:</b>						3474479.97
Support Coordination	15 minutes	1742	95.25	20.94	3474479.97	
<b>Supported Employment Total:</b>						34898.19
Supported Employment	15 minutes	18	185.53	10.45	34898.19	
<b>Personal Care 2 Total:</b>						7179.54
Personal Care 2	15 minutes	9	92.01	8.67	7179.54	
<b>Companion Care Total:</b>						1768887.70
Companion Care	15 minutes				1768887.70	
<b>GRAND TOTAL:</b>						7814877.23
Total Estimated Unduplicated Participants:						1742
Factor D (Divide total by number of participants):						4486.15
Average Length of Stay on the Waiver:						341

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		493	343.35	10.45		
<b>Environmental accessibility adaptations, (a.k.a., EAA) Total:</b>						256931.57
Environmental accessibility adaptations, (a.k.a., EAA)	unit	107	4.76	504.46	256931.57	
<b>Nutritional Supplements Total:</b>						19017.15
Nutritional Supplements	unit	40	4.76	99.88	19017.15	
<b>Specialized Medical Adaptive Equipment and Supplies (a.k.a., SMAES) Total:</b>						414591.84
Specialized Medical Adaptive Equipment and Supplies (a.k.a., SMAES)	unit	936	1.00	442.94	414591.84	
<b>Specialized Therapies Total:</b>						373500.00
Specialized Therapies	unit	249	12.00	125.00	373500.00	
<b>Vehicle Modification Total:</b>						168439.68
Vehicle Modification	unit	16	1.00	10527.48	168439.68	
<b>GRAND TOTAL:</b>						7814877.23
Total Estimated Unduplicated Participants:						1742
Factor D (Divide total by number of participants):						4486.15
Average Length of Stay on the Waiver:						341